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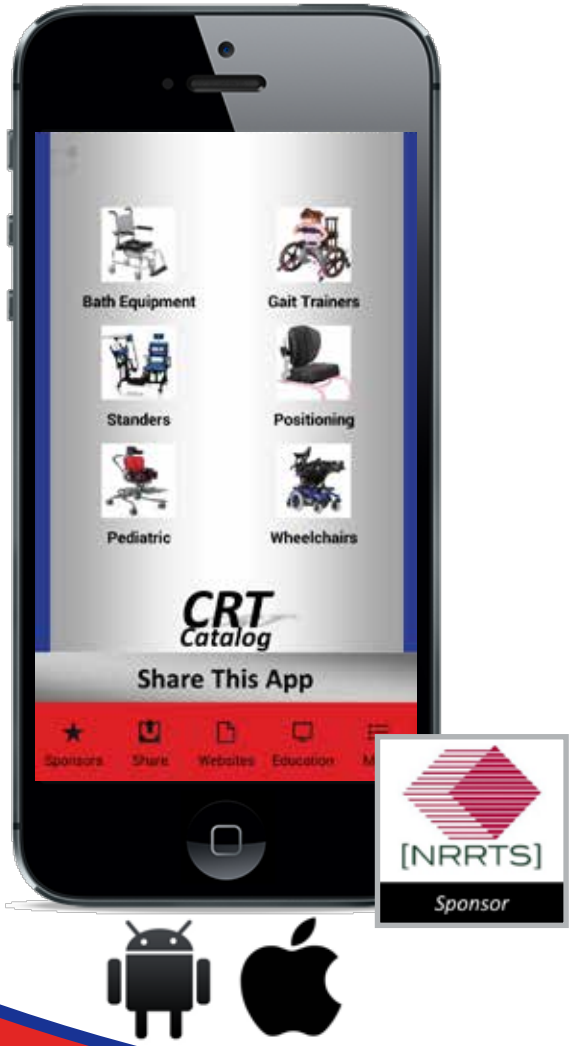

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IN THIS ISSUE

CLAUDIA AMORTEGUI

Amortegui has her Master of Business Administration and more than 20 years' experience in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) industry. Her experience comes from having worked on all sides of the industry, including as a DMEPOS Medicare contractor, supplier, manufacturer and consultant. For many of these years Amortegui has focused on the rehab side of the industry. Her work has allowed her to understand the different nuances of complex rehab versus standard durable medical equipment. This rare combination of industry experience enables Amortegui and her team at The Orion Group to assist Assistive Technology Professionals, referrals, reimbursement staff and funding sources in understanding the reimbursement process as it relates to complex rehab. SEE PAGE 48

ALEXANDRA (ALEX) BENNEWITH

Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at the federal and state level. She works closely with a range of stakeholders in the durable medical equipment and supplies, prescription drug, public health and disability communities. She graduated from Brandeis University and received her Master of Public Administration from American University. SEE PAGE 46

RICHARD BESETT

Besett is a certified Assistive Technology Professional (ATP) working for Shriners Hospital for Children as a Seating Technician II for the last 10 years. He assembles and fabricates commercial and custom wheelchair and seating solutions. He also assists therapists with seating evaluations and molded seating systems. SEE PAGE 42

DON CLAYBACK

Clayback is executive director of the National Coalition for Assistive and Rehab Technology (NCART). He has more than 25 years of experience in the Complex Rehab Technology and Home Medical Equipment industries as a provider, consultant and advocate and is actively involved in industry issues and a frequent speaker at state and national conferences. SEE PAGE 32

LAURA COHEN, PHD, PT, ATP

Cohen is the principal for Rehabilitation & Technology Consultants in Arlington, Va. She is the executive director of the Clinician Task Force (CTF), a national group of seating and mobility clinicians working to influence Medicare and Medicaid coding, coverage and payment policies for complex rehab and assistive technology devices. The CTF provides clinically relevant information about seating and wheeled mobility device assessment and decision making to policymakers to ensure appropriate access for individuals with disabilities. SEE PAGE 50

CRAIG KRAFT, BS, ATP/SMS

Kraft is the Seating Coordinator for Shriners Hospital for Children in Tampa, Fla. He manages the pediatric seating and mobility program for 1,200 children annually, which provides in-house seating and mobility services for the unfunded, post-operative positioning systems, and wheelchair prescription referrals to providers. SEE PAGE 42

MICHELLE LANGE, OTR, ABDA, ATP/SMS

Lange is an occupational therapist with more than 25 years of experience in the area of assistive technology. She is the former clinical director of the assistive technology clinics of The Children's Hospital of Denver and is now in private practice. Lange's work in assistive technology includes a broad range of roles and services. She is a well-respected lecturer, nationally and internationally and has authored seven book chapters and more than 175 articles. SEE PAGE 36

MIKE OSBORN, ATP, CRTS®

Osborn is president of NRRTS. Osborn has been a NRRTS Registrant since 2000 and is part owner of Alliance Rehab & Medical Equipment in Ozark, Mo. SEE PAGE 14

RICH SALM, ATP, CRTS®

Salm is a NRRTS Registrant in Colorado. SEE PAGE 28

JILL SPARACIO, OTR/L, ATP/SMS, ABDA

Sparacio is an occupational therapist in private practice in the Chicago area. A graduate of Western Michigan University, she currently provides occupational therapy services to children and adults with intellectual disabilities and medical fragility. Included in her consultation is a specialty of seating and wheeled mobility. Sparacio consults with seating manufacturers, often presenting clinical applications of seating and wheeled mobility products in addition to work on product development and design. She is the clinical educator for Pindot, a division of Invacare. She is a member of the Clinical Task Force and has been actively involved in funding and delivery issues on the state and national levels. She presents at seating and wheeled mobility conferences throughout North America as well as internationally. Sparacio has more than 30 years' experience as an occupational therapist. SEE PAGE 38

ANDREA VAN HOOK

Van Hook is the communications and marketing manager at RESNA. She has more than 18 years' experience working on successful, award-winning campaigns that promote equal access to health care, education and employment of diverse populations, including people with disabilities. SEE PAGE 52

CODY VERRETT, ATP

Verrett is President of ROVI and a friend of NRRTS. SEE PAGE 22

JENNIFER WOLFF, OTR/L

Wolff is the manager of UsersFirst, a program of United Spinal Association. Wolff is an occupational therapist and wheelchair user from Waverly, Iowa. SEE PAGE 46

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*NRRTS as well as the RESNA Professional Standards Board recognizes the International Association for Continuing Education and Training (IACET) as an international standard of quality. Though the words Continuing Education Unit (CEU) are not exclusive to IACET, only CEUs from an IACET authorized provider or accredited college or university, such as the University of Pittsburgh, are accepted as CEUs for NRRTS or RESNA recertification renewal.

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All participants must score a 70% on the post-test assessment to receive CEU credits.

TUESDAY, FEBRUARY 17, 2015 | 7PM - 8PM (ET)

Prop Sitters: Who, What, Where and When!

JILL SPARACIO, OTR/L, ATP/SMS, ABDA, MEMBER OF CTF

Seating individuals who lack the intrinsic muscle strength and control for active sitting present with certain challenges. The seating evaluation is key in determining what, where and why a type of external support is needed. Although neutral alignment should be key, the focus has to remain on function, often resulting in compromise. This webinar will identify characteristics that may result in the need for total support, the evaluation process and the process of generating specific recommendations for these individuals.

Jill Sparacio is an occupational therapist in private practice in the Chicago area. A graduate of Western Michigan University, she currently provides occupational therapy services to children and adults with intellectual disabilities and medical fragility. Included in her consultation is a specialty in seating and wheeled mobility. Sparacio consults with seating manufacturers, often presenting clinical applications of seating and wheeled mobility products in addition to work on product development and design. She is the clinical educator for Pindot, a division of Invacare and is a member of the Clinical Task Force and has been actively involved in funding and delivery issues on the state and national levels. Sparacio presents at seating and wheeled mobility conferences throughout North America as well as internationally. She has more than 30 years of experience as an occupational therapist.

WEDNESDAY, FEBRUARY 18, 2015 | 11AM - 12PM (ET)

Growing Evidence in Support of Orthotic-Based Seating Interventions

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JOAN PADGITT, PT, ATP

Wheelchair seating based on orthotic science has been successfully used to protect skin, improve stability, and manage heat and moisture. These successes have been reported through anecdotal experience and case studies. This webinar will summarize several recent studies comprising a body of evidence on how orthotic-based seating addresses sitting stability, microclimate, skin integrity and deep tissue deformation. The data collected includes the Modified Functional Reach Test, Interface Pressure Mapping and MRI studies on orthotic-based seating compared to an immersive air floatation wheelchair cushion. Preliminary human tester microclimate data using specially adapted temperature sensors will also be presented.

Joan Padgitt has specialized in wheeled seating and mobility since 1987 when she established the wheelchair clinic at Marianjoy Rehab Center in Wheaton, Ill. Padgitt joined Rick Jay's team at Jay Medical in Boulder, Colo., in 1989 where she was the director of educational programs. She has consulted and educated others on wheeled seating and mobility domestically and internationally with Jay Medical, Sunrise Medical, Flotech Medical and Aspen Seating/ Ride Designs. In 2007, Padgitt re-entered the clinical world as a practitioner with the Denver VA Wheelchair team. She is now back with the Ride Designs team directing the sales and education of this unique and innovative line of wheelchair seating interfaces.

THURSDAY, FEBRUARY 19, 2015 | 5PM - 6PM (ET)

Seating and Mobility Considerations for Persons with Multiple Sclerosis

BARBARA CRANE, PHD, PT, ATP/SMS, MEMBER OF CTF

Multiple sclerosis (MS) is a progressive neurological condition that poses many challenges in the provision of wheeled mobility and seating solutions. Sequela of MS include: muscle weakness, abnormalities in muscle tone, movement control disorders, and postural control problems. The resulting intricacy of client presentation increases the complexity of seating and mobility requirements for this population. MS is also characterized by fluctuations in severity and an unpredictable course of progression. This makes meeting current needs and anticipating future needs more difficult as well. This webinar will focus on potential seating and mobility solutions for this challenging population.

Barbara Crane is an associate professor of physical therapy at the University of Hartford in West Hartford, Conn. She has a BS in Physical Therapy from the University of Connecticut, in Storrs, Conn.; a MA in Gerontology from the University of Saint Joseph, West Hartford, Conn.; and a PhD in Rehabilitation Science and Technology from the University of Pittsburgh. A RESNA certified ATP and SMS, Crane has more than 20 years of clinical experience and has lectured extensively at national and international conferences.

TUESDAY, MARCH 24, 2015 | 7PM - 8PM (ET)

Approaching the Wheelchair Evaluation from all Angles: Roles and Responsibilities of the Team

LOIS BROWN, MPT, ATP/SMS

Having filled the roles of prescribing therapist, manufacturer, clinical educator and as an ATP working for an equipment supplier, Lois Brown has a unique perspective on the practice of wheelchair prescription and how the roles of the team vary but must complement and support one another. This webinar will use case examples and best practice guidelines to highlight these roles and an integrated problem-solving approach that leads to successful client outcomes.

Brown, MPT, ATP/SMS, is a physical therapist with 22 years of experience including more than five years of hands-on practice and full-time clinical education. Brown has presented nationally and internationally on wheeled mobility and seating and assistive technology, including ISS, ESS, CSMC and RESNA. She has been published in a variety of rehab publications and is considered an expert in her field.

WEDNESDAY, MARCH 25, 2015 | 11AM - 12PM (ET)

Gotcha! Key Considerations Before Providing a PMD to a Medicare Beneficiary

SPONSORED BY QUANTUM REHAB

JULIE PIRIANO , PT, ATP/SMS, MEMBER OF CTF

This course will examine the laws, rules and regulations that govern the provision of a power mobility device, the submission of a clean claim and accepting reimbursement from the Medicare Trust Fund. Included will be common claim denial scenarios related to the seven element order and product description, time frame issues, and home assessment requirements.

Julie Piriano, PT, ATP/SMS, is the director of Rehab Industry Affairs for Pride/Quantum Rehab and is actively involved with legislative and regulatory issues that impact Complex Rehab Technology. She serves on the RESNA board of directors, has served on the PSB, and is an active participant in the Wheeled Mobility and Seating SIG and the PT PSG. Piriano is a Friend of NRRTS, member of AAHomecare's Complex Rehab and Mobility Council, and NCART's Medicaid Committee. She also serves on the board of directors for several state associations and is a member of the four Durable Medical Equipment Medicare Adminstrative Contractor Advisory Councils.

THURSDAY, MARCH 26, 2015 | 5PM - 6PM (ET)

Clinical Documentation

BARBARA CRUME, PT, ATP, MEMBER OF CTF

Correct coding and documentation for therapy reimbursement is critical to the success of any outpatient clinic or home health provider. This course will provide information on Current Procedural Terminology (CPT) and how to use certain codes for wheelchair seating and mobility services. Documentation of the evaluation and treatment interventions will be presented through case examples and the use of templates to demonstrate provision of skilled care. This will include ways to justify the need for the assistive technology recommended. For those patients on Medicare, the use of G-codes will be included.

Barbara Crume, PT, ATP, works full time as a seating and mobility specialist with CarePartners Health Services in Asheville, North Carolina. She has more than 30 years of experience working with clients of all ages and all diagnoses to obtain manual and power wheelchairs with custom seating. She has presented courses at numerous conferences including ISS, RESNA, Medtrade and APTA. Crume has been an active member of the RESNA CPT Code Work Group, Standards Committee on Tissue Integrity and the Professional Standards Board. She served for four years as an executive board member on the Clinician Task Force.

TUESDAY, APRIL 14, 2015 | 7PM - 8PM (ET)

Ethics, Part 1: Moving through Specific Scenarios

WEESIE WALKER, ATP/SMS

This webinar presented by NRRTS executive director will provide an overview of the NRRTS Code of Ethics and Standards of Practice. Participants will learn about the NRRTS complaint procedure. Examples of how to apply these standards in everyday situations will also be presented.

Weesie Walker was an RTS for more than 30 years. She has served on the board of directors for NRRTS and GAMES as well as RESNA's Professional Standards board. She has presented at the International Seating Symposium, National Seating and Mobility Symposium, Georgia AMES, American Occupational Therapy Association conference, and Canadian Seating and Mobility Conference. Walker is currently the executive director for NRRTS.

THURSDAY, APRIL 16, 2015 | 5PM - 6PM (ET)

Ethics, Part 2: Overview of the Code of Ethics and Standards of Practice

WEESIE WALKER, ATP/SMS

This webinar will discuss ethics using specific examples from everyday practice. Ethics and standards of practice affect our industry. It is critical that we all understand the consequences and implications of malpractice.

Weesie Walker was an RTS for more than 30 years. She has served on the board of directors for NRRTS and GAMES as well as RESNA's Professional Standards board. She has presented at the International Seating Symposium, National Seating and Mobility Symposium, Georgia AMES, American Occupational Therapy Association conference, and Canadian Seating and Mobility Conference. Walker is currently the executive director of NRRTS.

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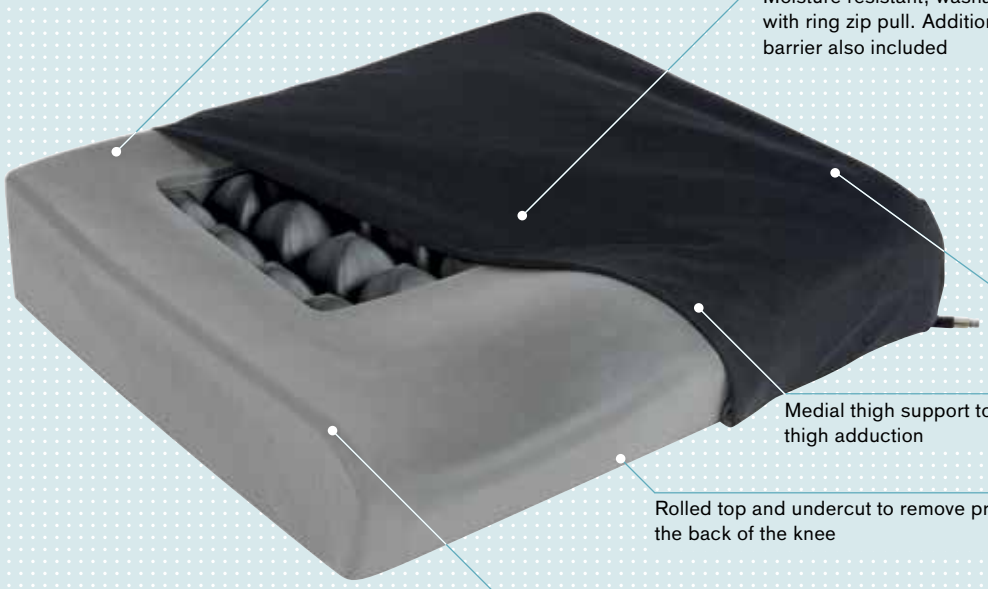

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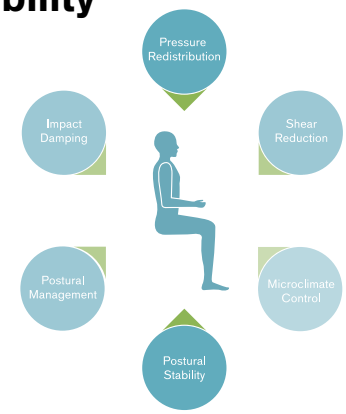

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FROM THE NRRTS OFFICE

NRRTS IN THE NEW YEAR

WRITTEN BY: MIKE OSBORN, ATP, CRTS®

As 2015 begins and we look back at the roller coaster ride that was 2014, let me remind you that the excitement is not over. The new year is starting just as fast as the last year ended. I know if you're like me, you've already laid out your plan of attack for 2015 and have filled your calendar with goals to accomplish and meetings to attend. NRRTS has been busy putting the same type of planning together for 2015.

NRRTS is always trying to find new ways to enhance all areas of operations and increase the quality it provides to the industry. In order to continue increasing the quality of service NRRTS offers to the Complex Rehab Technology (CRT) provider, we have expanded our staff this year, bringing on two new individuals. Mary Blake Vint will be taking over as association affairs coordinator and taking charge of renewals and customer service activities for NRRTS. Annette Hodges is stepping in as our new webinar coordinator and continuing the high level of education NRRTS has been able to offer. These two women join Amy Odom, director of marketing and operations, and Weesie Walker, ATP/SMS, executive director. NRRTS is also enhancing our social media tools this year with updates to our Facebook page and interacting with the industry through Twitter.

As always, a big part of NRRTS planning surrounds the National CRT Conference. NRRTS and NCART work very hard every year pulling this conference together. It takes many hours of work and planning to put together such an event. This year the conference will be held April 21 through April 23. The meeting location will continue this year at the Hyatt Regency Crystal City in Arlington, Va. This was my favorite event attended last year. The three days were full of education and networking capped off with a great day on Capitol Hill. I expect the same to be true this year.

NRRTS IS ALWAYS TRYING TO FIND NEW WAYS TO ENHANCE ALL AREAS OF OPERATIONS AND INCREASE THE QUALITY IT PROVIDES TO THE INDUSTRY.

While all of us have hectic schedules and full calendars it is important to remember that the industry, while widespread, is small. Many of us are competitors, but at the same time depend upon each other to exist. Everyone, when making the effort, can affect change. I encourage everyone to take part in the CRT Conference in some way. If you cannot make the trip to Washington, D.C., there are a multitude of activities and things you can do right from your computer. NRRTS is happy to offer its services to assist you with those activities. Visit our website, Facebook page or utilize Twitter to spread the word about what is going on in your area of the industry. Share your stories and help us to make new stories this year.

CONTACT THE AUTHOR

Mike may be reached at mosborn@alliancerehabmed.com.

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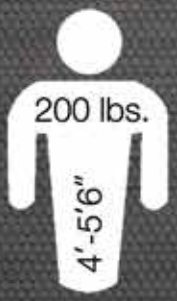

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ONE CAN MAKE A DIFFERENCE FOR MANY

WRITTEN BY: ROSA WALSTON LATIMER

Andrew Davis is a man of action. He lives a dynamic personal life that includes snow skiing and horseback riding. Professionally, he actively represents and advocates for others with physical handicaps.

Davis also lives with a disabling birth defect; however, he has adopted the positive attitude that "life does not end after spinal cord injury" and that attitude has shaped a life of purpose and determination.

For more than five years, Davis has held the responsibility of Consumer Relations and Advocacy for NRRTS, a position that has given him a broader platform from which to work for consumers and providers of Complex Rehab Technology. This advocate is an outstanding example of how one person, with patience and perseverance, can make a difference for many.

"When I was in college, I was the only person on that small campus who was disabled using a wheelchair and the campus was not wheelchair friendly," Davis recalls. "Until I made it wheelchair accessible." He notes this was before anyone had heard of the Americans with Disabilities Act. "I came up with a list of issues that needed to be addressed on campus such as wheelchair accessible bathroom stalls, handicap parking spaces that were actually made accessible, and a wheelchair lift in the science building so that a person could get up to the classrooms from the parking lot." Davis also advocated for desks designed specifically for students in wheelchairs.

> ANDREW DAVIS DESCRIBED THE FIRST 20 YEARS OF HIS LIFE AS "FILLED WITH 20 OPERATIONS AND YEARS OF PHYSICAL THERAPY, AS WELL AS THE BATTLE TO BE MAINSTREAMED INTO THE SCHOOL SYSTEM."

A few years ago, Davis grew tired of people abusing the handicap parking permits in his home state of Georgia. "So I decided to do something about it." He typed up a "position paper" of how he felt the handicap parking placards for the rearview mirror could be improved to eliminate abuse of the permits. He presented the paper to his state representative who agreed to sponsor it in the State House. Davis also met with committee members who would either approve or disapprove the idea of the bill. After presenting the idea and reasoning behind the draft legislation, the committee drafted

Halloween – 1970-something

Indian Guides

Andrew Davis with his brother, Wright, missed day of school due to snow

Dixie Wheelchair Games, 1985

met with Max Cleland; former Sec. of State for Georgia/1985 at State Capitol Met Georgia's former Secretary of State Max Cleland in 1985 at the state capitol.

a Bill that passed the State House unanimously. The next step was for Davis to contact his state senator seeking his support for the bill. Once again, the bill passed unanimously. As a result of Davis' efforts, Georgia handicap parking permits are now laminated and the expiration date is printed on the placard, rather than written with a black marker that faded in time allowing unlimited use of the benefit. Now it is more difficult for people without physical disabilities to abuse handicap placards, and it is easier for law enforcement and parking lot attendants to see the highly visible expiration date. Davis considers the somewhat lengthy process to accomplish this change well worth the effort. "This allows people with disabilities the opportunity to more fully participate in their communities." Davis sees this as his overriding goal in everything he does.

For those of you who aren't familiar with Davis' story, the 46-year-old was born with club feet and spina bifida myelomeningocele, a disabling birth defect. He later developed hydrocephalus. Davis described the first 20 years of his life as "filled with 20 operations and years of physical therapy, as well as the battle to be mainstreamed into the school system." Things then were much different than they are today. However, Davis attended regular neighborhood schools, went to college and earned a bachelor's degree.

Through the challenges of his life, Davis emerged as a productive individual who served as a hospital volunteer and mentored patients in rehab hospitals. He enjoys a variety of sports activities and lives an independent life that includes driving a hand-equipped car. Davis admits his current lifestyle would be impossible without his lightweight wheelchair and appropriate cushion. He understands that many others face this same challenge to maintain

(CONTINUED ON PAGE 18)

ONE CAN MAKE A DIFFERENCE...
(CONTINUED FROM PAGE 17)

independence. "That is why I am urging a separate benefit category for Complex Rehab Technology (CRT) – to make sure that people like me can have continued access to CRT equipment and be a part of the community in which we live."

Davis lives with, and in some instances overcame, the challenges that he now works to eliminate for others. Through his advocacy work, Davis now speaks – and acts – on behalf of the many who use complex rehab equipment. He is a precise, experienced representative of individuals, and families, who must work through an often complicated maze to gain access to desperately needed equipment and treatment. "I could not afford this kind of wheelchair or cushion on my own," Davis explained. "That's why I am urging funding sources to continue paying and even expand the funding for medical equipment. I feel it is our responsibility to help people of all abilities and disabilities develop to their highest potential."

With razor-sharp focus on getting a bill passed through Congress that would ensure access to quality CRT, Davis works at events such as Medtrade and the Abilities Expo, educating the public on the bill and always encouraging individuals to contact their members of Congress. He has also worked closely with Georgia Senator Johnny Isackson, Congressman Phil Gingrey, Representatives Doug Collins, John Lewis, Rob Woodall, and Tom Price, Georgia Sen. John Isakson and Reps. Phil Gingrey, Doug Collins, John Lewis, Rob Woodall and Tom Price, as well as other state Legislators and their aides for the purpose of keeping them apprised of the merits of a bill supporting the Separate Benefit Category for CRT and enlisting their support.

Davis created and maintains a contact list of organizations that advocate for the disabled. He uses this information to regularly communicate with these groups asking their members who use CRT equipment to contact their representatives and senators to educate them about CRT legislation and solicit support for the bill. While working with NRRTS, Davis has also organized volunteers to help obtain a petition of more than 500 signatures of individuals, including CRT suppliers, who support the concept of a separate benefit category. The petition was presented to Rep. Jack Kingston's legislative aide in Washington, D.C.

Don Clayback, Executive Director of NCART, recognizes Davis' commitment and effectiveness. "Andrew has been very helpful in our work to get the CRT legislation passed. He has had multiple meetings with both staff and members of Congress and has also reached out to physicians and others to enlist their help," Clayback noted. "As we all know, this type of work requires both dedication and persistence. Andrew is a great example of both and that makes him a great advocate. We're looking forward to his continued assistance as we move into 2015."

"It is important for legislators to have a better understanding of different disabilities," Davis explained. "Once they understand that one size doesn't fit all when it comes to adaptive equipment, rehab technology and related services, they realize the crucial need for a change in the way reimbursement is managed."

As part of the CELA (Continuing Education and Legislative Advocacy) annual conference, Davis participates with a group of approximately 30 consumers, providers and NRRTS representatives who meet with legislative aides. The primary purpose of these face-to-face meetings is to build a relationship with legislators and staffers. Davis realizes these personal conversations have led to a better understanding of the complexity of issues faced by consumers and providers.

"I can see progress being made each year," he said. "Legislators and their staff are now better educated and more responsive to our issues."

Through these efforts, legislation has been introduced in Congress to create a Separate Benefit Category within the Medicare program. "I strongly encourage everyone to contact your members of Congress," Davis said. "Relate your

(CONTINUED ON PAGE 20)

Meeting with Rep. Rob Woodall

Andrew on cover of New Mobility

At Dulles Airport, welcomng the consumers to CELA

Junior Ball/Junior Committee-to raise funds for Recreation Department at Shepherd Center

Handing Legislative Aide for Congressman Kingston a paper petiton (500 signatures) from his Constituents who feel H.R. 942 is something he should support Legislative aide for Rep. Jack Kingston accepts a paper petition (500 signatures) from his constituents who believe he should support HR 942.

In front of White House

Meeting Rep. John Lewis

Andrew and Sen. John Isakson

Martin Luther King Jr. Center in Atlanta, Ga.

ONE CAN MAKE A DIFFERENCE ...
(CONTINUED FROM PAGE 19)

personal story and ask them to support the bill, 'Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013' in the House and the Senate."

CRT must be separately recognized in order to improve and protect access for people with disabilities who rely on CRT for their medical and functional needs.

If you are ready to join Davis and others in this activism for consumers and providers of complex rehab technology CRT, don't hesitate. It is as simple as communicating with your local, state and federal elected officials. The U.S. Capitol switchboard number is 202-224-3121.

Davis' attitude that "life does not end after spinal cord injury" inspires us all to support this work. You, too, can make a difference for many.

CONTACT

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WHEELIN' AND DEALIN'

ROVI MOBILITY PRODUCTS PRESIDENT WINNING WITH CAREER COLLABORATION

WRITTEN BY: DANETTE BAKER

Cody Verrett, ATP, rolled the dice several times throughout his career, accepting the challenges and opportunities offered him from those in the complex rehab industry. His best hand, however, might just be returning to his roots in manufacturing.

DIRECTIONS recently had the opportunity to visit with Verrett, president of ROVI Mobility Products, to learn more about his venture through the industry and what's new on the horizon.

HOW DID YOU BECOME INTERESTED IN THE MEDICAL EQUIPMENT INDUSTRY?

In 1976, my mom was diagnosed with a brain tumor, and treatment left her with a seizure disorder and hemiparesis. She was a single mother, and I was just 4 years old. Her condition left her paralyzed on her left side. For a few years she used a cane and that progressed to a walker and quickly to a tilt-n-space manual wheelchair, which she used for the last 25 or so years of her life. She needed full-time care, so she was eventually placed at Good Shepherd in Allentown, Penn.

Naturally, I grew up with a different understanding of disabilities than most people, but it was my wife, Nicole, who introduced me to the industry. I had a degree in exercise science and was working in the health club industry, which I disliked, and I was struggling to make ends meet. My wife was just out of occupational therapy school and was working at the University of Maryland Medical Center in Baltimore. She met a representative of M&W Medical Equipment at an in service. He told her afterward they were looking to expand and explained to her there was an opportunity for someone who would work hard and was fairly mechanically inclined. This person needed to be good with people and wouldn't have any reservations about working with people who have disabilities. My wife came home and said, "I think I found a perfect job for you."

> MY WIFE CAME HOME AND SAID, "I THINK I FOUND A PERFECT JOB FOR YOU."

I was always fairly mechanically inclined. I was that kind of kid who could take a bicycle completely apart and put it back together, so that part of the job was a good fit for me. Not only did it turn out to be a new and exciting vocation or trade so to speak, but I got to apply some of my experience with my mom's chair and her seating and positioning, which helped me make a pretty smooth transition into the industry.

My start came in the mid '90s, and I absolutely fell in love with the business and never looked back. There are few industries that offer the reward and satisfaction of making a positive difference in someone's life, like you commonly experience in the assistive technology industry.

Unfortunately, M&W Medical Equipment fell on some hard times financially. They tried to expand into respiratory, and it became a burden and got them away from what they had started the business on, which was standard durable medical equipment and complex rehab. Eventually, it became too risky for me. I had just gotten married and we were about to have our first child, so I had to find a new opportunity. One of my duties at M&W was to do all my own purchasing, which put me on the phone with manufacturers all the time. I made friends with an inside sales person at Pride Mobility Products, and he told me about an outside sales position that was available right where I lived. I was thrilled to be hired at Pride when I joined them in the fall of 1999 as a rehab specialist.

Over the next decade, I held positions with Pride's complex rehab division, Quantum Rehab, working in research and development and education and eventually served as the national sales director. I left Quantum in 2010 to join Paul Bergantino and the team at ATG Rehab, where I focused my attention on growth initiatives through recruitment of ATPs, account development and acquisitions. In January of 2013, Shoprider approached me with a unique opportunity to create something brand new. Shoprider is the consumer mobility division of Pihsiang Machinery and

Manufacturing Corporation, a publicly held company in Taiwan. Pihsiang has strong expertise in electric vehicles, but not just mobility in the sense of scooters and power wheelchairs. They make electric cars and trucks that are sold in Europe and Asia, and they have a very diverse business in fuel cell battery technology — lithium-iron, phosphate battery technology, specifically. It was their depth of experience and technology that made it easy to roll the dice in April 2013 and join them to start ROVI, the corporation's complex power mobility division.

I enjoy sales, talking to people and sharing something that has value, but I recognized while I was at ATG that I missed making a device, a product, a thing, being creative, and honing it into something terrific and then replicating that over and over again. I was very excited to come back to the manufacturing side, and I'm grateful for this opportunity.

WHAT ARE SOME OF THE MOST SIGNIFICANT MILESTONES IN YOUR CAREER?

I'm very fortunate to have some very rewarding moments in my career, but there are a few that stand out.

In Baltimore in 1998, I delivered a manual wheelchair for a young girl who I fondly remember. She was so happy that I never forgot the smile on her face and how proud it made her feel.

In 2004, when I moved my family to Pennsylvania to work for Quantum, I was fortunate to work with an incredibly talented group of people. We helped influence an evolution in quality and product design that yielded such innovations as the Q600, Q6000, Q6 Edge, Tru-Balance2 and Q-Logic, to name just a few.

With ATG Rehab, I was part of a growth run that peaked with us joining United Seating & Mobility and creating what is today, the largest complex rehab provider in the world, Numotion.

Then in 2013, I began this new venture at ROVI, and in the next month or so, we'll be introducing our first product.

WHO HAS BEEN INSTRUMENTAL IN THOSE ACCOMPLISHMENTS?

I've learned a great deal along the way from some really smart people, but the person who has been most instrumental in these accomplishments is my wife. More than any other person, she's given me incredibly good advice along the way.

(CONTINUED ON PAGE 24)

Cody and his mom, 1977

WHEELIN' AND DEALIN'
(CONTINUED FROM PAGE 23)

First and foremost, she made that very early introduction that set in motion my career with M&W Medical Equipment. With her experience as an occupational therapist, I can go to her with variety of different situations for advice. For example, anytime I have a product or process idea I can always get her perspective and advice on how to approach the clinicians. She always gives me very clear guidance about what is important to them, which is an incredibly valuable piece of the sales process. She also has always been incredibly supportive of my decisions.

When I was considering the move to ATG, she encouraged me to pursue it and expressed how she thought it would be a good transition for us and our family. It turned out to be a great move for me; I learned a lot about myself. It let me regain focus on the process from the consumer's perspective and take inventory of what matters most.

WE COULD CREATE THE X3 TOGETHER UTILIZING OUR COLLECTIVE EXPERIENCE AND WITH MOTION'S OUTSTANDING SEATING SOLUTIONS, WE MIGHT BE ABLE TO CREATE SOMETHING TRULY INNOVATIVE. AND THAT'S WHAT WE DID.

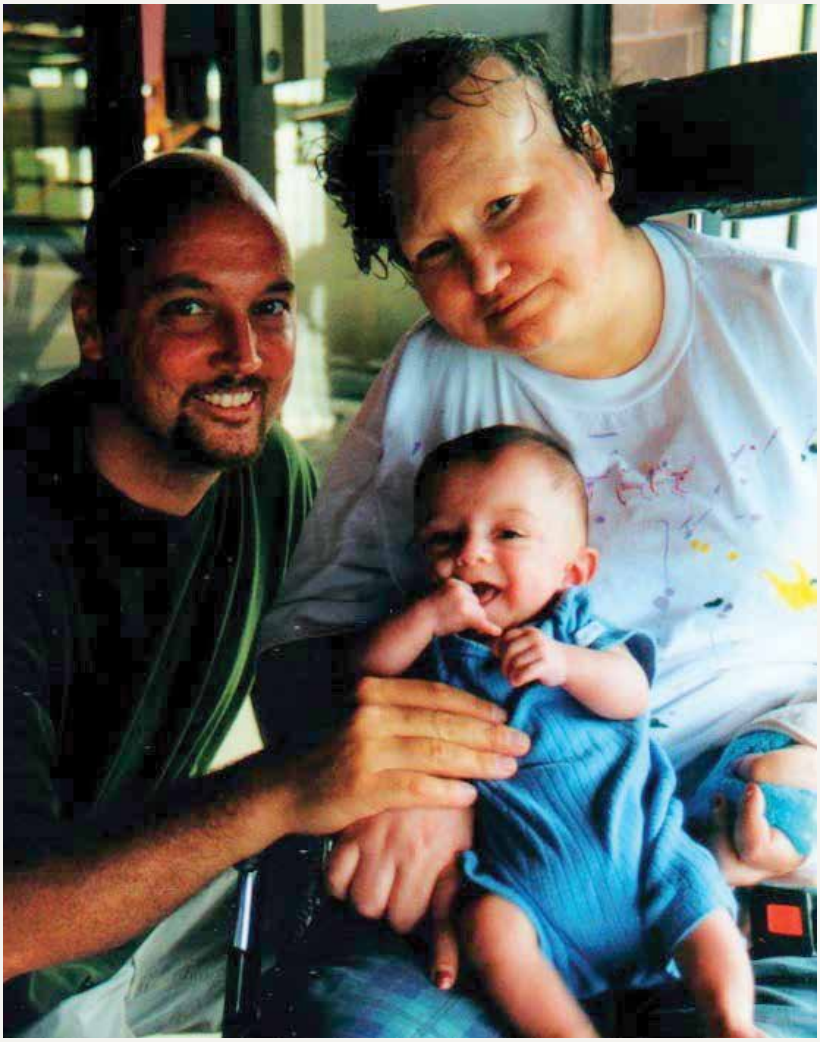
WHAT ARE THE FUTURE CHALLENGES FOR ROVI MOBILITY PRODUCTS AND THE INDUSTRY AS A WHOLE?

Our biggest challenge at ROVI is to successfully introduce the ROVI X3 system by Motion Concepts. We secured our 510K from the Food and Drug Administration, and we expect to have our Medicare PDAC (Pricing, Analysis and Coding) in the first quarter of 2015.

In starting ROVI, we focused on leveraging our strengths and adding value. When the X3 was an idea and a rough sketch, we approached Motion Concepts with an opportunity to collaborate differently. The process was exciting and creatively authentic. Together, our unique approach to the complete X3 system has created a product that is getting very positive feedback from industry insiders.

From the manufacturing perspective, I believe the biggest challenge facing our side of the industry is to continually innovate and deliver quality product choices, while remaining completely in sync with the difficult reimbursement challenges faced by providers.

Cody, his mom and his son, Reece



WHAT'S ON THE HORIZON FOR ROVI MOBILITY PRODUCTS?

We look forward to more collaboration with our friends at Motion Concepts to design a narrow, but meaningful line-up of power base choices with ROVI's unique chassis configuration and suspension as the cornerstone.

I alluded to the relationship we have with Motion Concepts and how that came into play. What this relationship really focuses on is maximizing our strengths and adding value. I was confident we could create a great power base, but it's worthless without excellent seating and positioning. In my first few weeks on the job, I reached out to my friends at Motion Concepts and pitched the idea of creating a unique power base solution that would be exclusively for them. We could create the X3 together utilizing our collective experience and with Motion's outstanding seating solutions, we might be able to create something truly innovative. And that's what we did. We have spent the last 18 months creating the ROVI X3 system by Motion Concepts into something that makes us all very proud.

ROVI's mission is to develop products with useful and independence-enhancing features, and the X3 is just the beginning.

WHAT AREAS IN THE INDUSTRY HAS ROVI MOBILITY PRODUCTS TAKEN A LEAD IN?

Specific to complex power mobility, ROVI is charting a new pathway to market. During the process of developing the X3, we had to think differently in a variety of ways. One of the unique things about the ROVI X3 is that we positioned the batteries differently than any other power base

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WHEELIN' AND DEALIN'
(CONTINUED FROM PAGE 25)

on the market. Everyone puts them into chairs in exactly the same way, in a landscape configuration. We turned them in a portrait position, which actually allows more mass distribution through the center of chair and increases its center of gravity. We knew this design would create a narrower wheelbase, which would obviously be beneficial for maneuvering through doorways, up ramps, etc. What we stumbled upon — and what was our "Eureka" moment — was that this elongated weight distribution makes the chair more stable as well. That was a terrific discovery during the development process. Make no mistake though, innovative design or not, we must deliver product solutions for consumers that exceed their expectations for quality and reliability because that's what really matters.

WHAT CHANGES WOULD YOU LIKE TO SEE IN THE INDUSTRY?

I'd like to see Congress to pass HR 942 and S 948. We need meaningful legislation to protect access to complex rehab equipment. I've been so focused on getting ROVI started that for the past 18 months that I've missed some advocacy events, but I'm looking forward to attending the National CRT Leadership & Advocacy Conference in April and going back up on the Hill.

We need this legislation because Complex Rehab Technology (CRT) needs to be separately recognized in order to improve and protect access for people with significant disabilities who rely on these products for their serious medical and functional needs.

WHAT HAS KEPT YOU WORKING IN THE INDUSTRY?

It's definitely the people. The vast majority of people in this business are totally committed to enhancing the lives of others, and that genuine kindness and compassion, often mixed with a no-bull, straightforward nature is fun to be around.

That first milestone I mentioned, about providing that little girl with her first chair — that was when I was really knew this is what I was meant to do. Going from nothing to having her first set of wheels and seeing just how proud she was to sit in that chair and be upright and independent, interacting with her family and siblings was a powerful moment for me professionally and something I'll never forget. Expanding that experience for others is definitely a driving force for why I remain in this incredibly rewarding industry. The second part of the answer takes me back to my childhood and my mom and the limitations she had. As I've gotten older, I've never forgotten about my mom's mobility limitations, and I think that has driven me to continually create and be part something that makes a difference. Each day at ROVI we are trying to make things better for people with mobility limitations. This is an exciting industry, and it makes me jump out of bed each morning.

WHAT OTHER ROLES DO YOU HAVE IN THE MEDICAL EQUIPMENT/COMPLEX REHAB INDUSTRIES (BOARDS, ASSOCIATION MEMBERSHIPS, ETC.)?

I've been an ATP since 2006. I'm also a Friend of NRRTS and I've been a mentor to industrial design and engineering students interested in this field.

WHAT DOES A TYPICAL WORK DAY/WEEK LOOK LIKE FOR YOU?

I work a flexible long day, and what I mean by that is that I work from my home office in southern New Jersey, so I start early and often end late, but I take breaks as necessary to attend to personal matters. I travel frequently to our Los Angeles office and, with time zone differences, sometimes that can be a 12- to 15-hour day. ROVI is demanding on my time, but a few years ago I set out to intentionally realign my priorities and since then I've been able to find a good balance that works for me and my family.

WHAT'S LIFE OUTSIDE OF THE 9 TO 5 LIKE FOR CODY VERRETT?

I love to be outside, either biking or walking my dogs. If it's nice outside, I can usually find an hour in my schedule to do one or the other. I also enjoy our family time with our 14-year-old son, Reece. We also had another son, Hudson, who would have been 11 today (Dec. 2). He was born prematurely at 2 pounds, 11 ounces and died 25 days later from complications. Reece was also a preemie, weighing only 1 pound, 6 ounces, and today he's a freshman in high school. They are both constant reminders about how precious life is, how fragile we all are, and that we have a limited amount of time on earth to make a difference for others.

CONTACT
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NOTES FROM THE FIELD

BUILDING RELATIONSHIPS:

SALM FINDS BRINGING RIGHT GROUPS TO THE TABLE KEY TO SUCCESS IN COLORADO

WRITTEN BY: JULIE BARNETT

Richard Salm has spent the past 25 years focusing on Complex Rehab Technology and, particularly in the last decade, become closely involved in governmental relations to ensure that the disability community has adequate access to the equipment and services they need.

Salm has been in the home medical equipment industry since 1983, with his sole focus the past 25 years being on CRT, first as a seating mobility specialist. He was among the first group to complete corsework and sit for and pass RESNA's ATP exam.

He became a NRRTS registrant in 1996 and has been an engaged and active participant from the beginning, serving in leadership roles including director and chairman of the Ethics Committee. During his tenure, he was instrumental in changing the bylaws to include a committee of three rather than solely a chair.

Salm served two terms on the RESNA Professional Standards Board, also participating in revising the complaints process for that board. He also was involved in revising the standards for the recertification process. During this time, he began his own CRT business, Peak Wheelchairs, in Colorado, which he managed for 13 years with three locations in the state at its height. He sold the business in 2011.

Most recently Salm served in the contracting department for Numotion in Hazelwood, Mo., negotiating managed care contracts for the company, where he solved complex payor problems, as well as being involved in government affairs mainly for the state of Colorado, and sitting on the Colorado Medicaid Advisory Committee for about the past 12 years. He's been very active in Colorado on health care policy issues, which dovetailed into his Numotion responsibilities.

Indeed, his involvement in Colorado policy issues led to a successful partnership resulting in separate recognition legislation, HB 1211, passing in Colorado last year. Working with the Colorado Association for Medical Equipment Services (CAMES), the group developed a unique partnership with the disabled community, Colorado Medicaid and many others resulting in the significant crowning achievement.

Salm said the involved and lengthy process began in April 2013. "My boss at the time gave me a work assignment to pursue drafting separate recognition legislation in Colorado," he said. His first step was going to CAMES, of which he was a board member, where he proposed that they adopt separate recognition legislation as an initiative. The board unanimously approved to pursue it.

This allowed access to CAMES lobbying firm, Busam & Aponte. "Edie Busam was our lobbyist, and we were fortunate in that she had been from our industry in orthotics and prosthetics," he said. "She has been very effective for CAMES over the years."

> "WE WERE HOPING THAT COLORADO MEDICAID WOULD COME OUT IN SUPPORT. OUR TRUE HOPE WAS THAT THEY WOULD COME BACK AND BE NEUTRAL ABOUT IT, NOT OPPOSE THE BILL."

The next stop after going to CAMES was to visit with Julie Reiskin, executive director for the Colorado Cross-Disability Coalition, an advocacy organization that's very active and very well organized, Salm said. He felt it was key to have them on board early in the process.

"They are well-known amongst policymakers and legislators in Colorado, and have tremendous power," he said. "Their motto is 'nothing about us without us.' I shared the draft legislation with Julie, and right away she recognized the importance of what we were doing. Her organization not only backed it, but decided to make it a top priority in 2014."

Salm next shared a draft of the legislation with Colorado Medicaid, who said they would have a legal team look at it and get back with comments. "We were hoping that Colorado Medicaid would come out in support. Our true hope was that they would come back and be neutral about it, not oppose the bill," he said.

The next part of the process was to attend legislative fundraisers for both parties, attending events where they could meet with various legislators of the House and Senate and start selling the bill. "We were letting them know what the bill was about, to ensure that people with complex needs would have access to services and technology to function at their highest level possible, gain employment, fully participate in life in general," Salm said, "and to protect benefits to ensure they were provided services by adequately staffed and qualified providers for complex technology."

Also active on the board was Patrick Mahnke, president and owner of USA Mobility, a CRT provider in Colorado. "We worked on the language so all were supportive of the bill and in agreement," Salm said. "During this time, Colorado Medicaid came back to us with a list of concerns and objections about language. We worked and negotiated language changes and clarifications to satisfy their concerns."

Colorado Medicaid, however, was adamantly opposed to the bill and did their best to try to kill it, Salm said. "They took it to a fiscal analyst who calculated how much it would cost the Department of Health Care Policy and Finance (HCPF), who found it came with a $15 million price tag," Salm said, which would have ensured the death of the bill. "I personally reviewed the analysis and was able to figure out where the errors were," Salm continued, "through process of clarification and negotiation of the language, we were able to get the $15 million reduced to a manageable $15,000."

The department adopted a neutral stance and dropped all objections. At this point no stakeholders opposed the bill, which really paved the way to move

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BUILDING RELATIONSHIPS
(CONTINUED FROM PAGE 29)

the legislation forward. "We did a lot of work upfront to gain or neutralize approval," he said. "By the time the bill was introduced to the House committee, Edie (Busam) had done her magic behind the scenes, and we knew before voting in committee that it was going to pass."

Then it passed the House committee 12-1, and the Senate committee unanimously passed it 7-0. In fact, the Senate committee thanked the team for doing all the work beforehand, and getting the stakeholders on the same page.

NRRTS IS THE ONLY ORGANIZATION THAT IS MADE UP OF RTSs, IS FOR, ABOUT AND BY RTSs, AND IS THE ONLY ORGANIZATION THAT IS DEDICATED TO THIS SECTOR OF THE INDUSTRY.

On May 23, 2014, Colorado Governor, John Hickenlooper signed the bill into law. "The great thing was it was really not the first separate recognition to pass, but was the first to pass that provides protection for the rates. It also protected payment methodology to ensure CRT as a purchase item," Salm said. Also, a provision was carved out that protects CRT from being placed in a bidding scenario, as well as requiring CRT providers be accredited and have adequate staff, facilities and stock of parts.

Salm said as great as passage of the bill was, it was only one of nine pieces of disability legislation that got passed in the 2014 session in Colorado between CAMES and CCDC. CAMES also initiated a licensure bill to help protect in-state providers from out-of-state bidders with no intention to provide services in Colorado.

Salm said many people were instrumental in the bill's success, including two who were key during the process: Don Clayback with NCART and Vickie Agler with the Busam & Aponte lobby firm, who did a lot of heavy lifting with language changes from the various entities, managing and tracking the multitude of revisions and changes.

Since the bill's passage, Salm has been engaged with Colorado Medicaid and a wheelchair benefits collaborative group to work with the Department of Health Care Policy and Finance to start incorporating language so that once the bill passed, less work would be needed to revise policy. "As of Jan. 1, 2015, the policy is in effect," Salm said.

Recently, Salm has been very engaged in the Oklahoma state managed care program. "CRT in particular has been hit extremely hard," he said, noting that suppliers are having to reduce access to necessary equipment and services. In the state, he's helped to organize a CRT workgroup to reach out to legislators to fight rate cuts. Currently, there is proposed legislation in Oklahoma to create separate recognition. "We've been making progress, but have quite a ways to go," he said. "With the status of the state's budget, it likely won't happen any time soon."

But he knows the best way to ensure it does eventually happen is to continue to build those coalitions, and to work together as a profession.

"First and foremost, NRRTS is the only organization that is made up of RTSs, is for, about and by RTSs, and is the only organization that is dedicated to this sector of the industry," he said. "I've been fortunate to have found my way into this industry by luck, and NRRTS is the best vehicle to be able to give back to the industry, to shape the profession into what we want it to be. I appreciate the organization, the camaraderie, our mission and what we stand for.

"If we want to professionalize ourselves, it's up to us to create it, take part in it, shape it," he continued. "It's our opportunity to give back and participate in the process more than necessarily to seek benefit. And of course it provides CEUs, leadership on legislative and policy issues and raises the standards of the profession."

CONTACT

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CRT UPDATE

FEDERAL CRT LEGISLATION

WRITTEN BY: DON CLAYBACK

We start 2015 with a strong base of support from last year that sets the stage for the reintroduction and passage of the "Ensuring Access to Quality Complex Rehabilitation Technology Act" this year.

We ended 2014 with 168 House members on HR942 and 22 Senate members on S948. Our sponsors and co-sponsors provide evidence of solid bipartisan support and include members of the key Congressional committees that have jurisdiction over the Medicare program. We also have more than 50 national consumer and clinical groups formally signed on. While we did not get the legislation passed in 2014, we established an excellent foundation to get it over the finish line this session.

The first quarter of the 2015 Congressional session will be a very busy time. On the health care side, Congress must take up legislation to further delay or repeal the Medicare sustainable growth rate (SGR) methodology, which calls for physician fee cuts of more than 25 percent. Currently, these cuts have been delayed until March 31 and Congress must (and will) take action to prevent the cuts from going into effect. This will be the first Medicare legislation in the new year and presents the first potential opportunity to get our Complex Rehab Technology (CRT) legislation included as part of a bigger bill.

The following are key components of our 2015 plans: (a) update legislation language – we are working with our sponsors to make select changes to the legislation to address Medicare changes over the last two years that have or will hurt CRT access; (b) reintroduce the Senate and House bills – Senators Thad Cochran (R-MS) and Chuck Schumer (D-NY) and Representatives Jim Sensenbrenner (R-WI) and Joe Crowley (D-NY) Sens. Thad Cochran, R-Miss., and Chuck Schumer, D-N.Y., and Reps. Jim Sensenbrenner, R-Wis., and Joe Crowley, D-N.Y., have recommitted to reintroduce our bill in both chambers; (c) sign on previous co-sponsors – once the bill is reintroduced we will have the new bill numbers and will resume our grassroots outreach with all stakeholders reaching out to their members to get them to sign back on; (d) secure support from key Medicare committees in Congress – we will be continuing to work with the Senate Finance Committee and the House Ways and Means Committee to gain their input and support; (e) obtain favorable Congressional Budget Office (CBO) score – the CBO needs to calculate the official cost of our bill, and we will be working to ensure an accurate report.

As soon as we have our new bill numbers we will be making that announcement and updating all of our related legislative materials. Remember to use the resources at www.access2crt.org to help in your advocacy efforts. Thanks to all for continuing to carry the CRT message to your members of Congress. Stay tuned for more updates and get ready for a busy and productive year.

NEGATIVE MEDICARE RULE

As we have reported, Centers for Medicare and Medicaid issued Final Rule CMS 1614-F containing a variety of significant changes impacting access and payment relating to Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit.

The rule contains a variety of provisions, including how CMS will use information obtained through the Medicare Competitive Bid Program to make national pricing adjustments for competitively bid items provided in non-bid areas. The rule provides those details and related payment rate changes that will go into effect January 1, 2016.

From a CRT perspective, the greatest concern that we communicated during the rule's public comment period (prior to it being finalized) was that CMS must preserve the current Medicare policy that provides that competitively bid accessories furnished with CRT manual and power wheelchair bases to be paid at the traditional Medicare fee schedule amounts (not at competitively bid rates). When final rule CMS 1614-F was published in November this issue was not directly addressed so we immediately followed up with CMS for clarification. An answer was finally provided in a CMS Frequently Asked Question (FAQ) released in late December.

Unfortunately, the answer in the FAQ document indicates CMS intends on

eliminating the current policy that pays for these competitively bid accessories at traditional fee schedule amounts. Instead, starting in 2016, these accessories will be paid at the bid rate whether they are provided on a standard wheelchair base or a CRT wheelchair base. This goes against legislation passed by Congress in 2008 that established the exclusion of CRT power wheelchairs and accessories from the Competitive Bid Program and will result in significant payment cuts to important accessories used on CRT wheelchairs.

This will create a major access issue and must be rescinded. If left unchanged it will have significant negative consequences to people with disabilities who rely on CRT to meet their medical and functional needs. And since other payers follow Medicare policies these negative consequences will extend well beyond just those enrolled in the Medicare program to include those covered by Medicaid and other health insurance plans.

As of this writing we are currently working on a detailed analysis and will be issuing additional details and guidance as we move through the first quarter. We will continue to try and work with CMS but also have begun discussions with our Congressional champions and will be engaging them in reaching out to CMS and exploring potential legislative solutions to prevent a Jan. 1, 2016, implementation. More to come.

NATIONAL CRT CONFERENCE

It's time to sign up for the third annual National CRT Leadership and Advocacy Conference, which will be held April 21 - April 23, at the Hyatt Regency Crystal City in Arlington, Va. NCART and NRRTS are again bringing CRT providers, manufacturers, clinicians,

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FEDERAL CRT LEGISLATION
(CONTINUED FROM PAGE 33)

consumers and other stakeholders together in one place for high value education, networking and advocacy.

As a reminder, the three-day program consists of: Leadership Day – business presentations and breakout sessions for the management teams of CRT providers and manufacturers; Advocacy Day – funding and advocacy sessions for all CRT stakeholders covering the latest Medicare and Medicaid trends, issues and advocacy strategies relating to CRT coverage and payment; and Capitol Hill Day (CELA) – the historic cornerstone event for taking the CRT message directly to Congress through personal visits with members of Congress and their staff.

You can get more details and register online at www.ncart.us or www.nrrts.org. Discounts are available for multiple attendees from the same company. Don't miss this opportunity for ideas to strengthen your business or practice and to promote the CRT advocacy message with Congress.

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MEDICAL FOCUS

CEREBRAL PALSY

WRITTEN BY: MICHELLE L. LANGE, OTR/L, ABDA, ATP/SMS

This column is a new feature to the DIRECTIONS magazine. Medical Focus will take a deeper look at a specific medical condition or intervention to provide you, the reader, with a review and update. We hope you find this information helpful and look forward to your feedback.

According to the Centers for Disease Control and Prevention, about 3.3 in 1,000 children have cerebral palsy. Cerebral palsy (CP), which is the leading cause of childhood disabilities. CP is not a single disease, but a group of conditions that affects parts of the brain controlling muscle movement and coordination. CP is caused by abnormal development of or damage to parts of the brain before, during or shortly after birth and is not progressive. Often the cause is unknown, though specific causes may include genetic abnormalities, brain malformations, maternal infections or fevers and fetal injury.

CP is an umbrella term, and you may work with clients who have a more specific sub-diagnosis.

- Periventricular Leukomalacia is damage to the white matter of the brain that looks like tiny holes, and these gaps in brain tissue interfere with brain signal transmission.
- Cerebral Dysgenesis is abnormal development of the brain and is often caused by genetic mutations, though infections, fevers and trauma can also be contributing factors.
- Intracranial Hemorrhage is bleeding inside the brain from blocked or broken blood vessels, typically caused by a fetal stroke. Fetal stroke may occur due to blood clots in the placenta, malformed or weak blood vessels in the brain, blood clotting abnormalities and maternal high blood pressure.
- Asphyxia is a lack of oxygen in the brain and can occur during labor and delivery. A specific type of brain damage is hypoxic-ischemic encephalopathy in which part of the cerebral motor cortex and other areas are destroyed due to a prolonged lack of oxygen.

Specific types of CP are classified by the extent, type and location of involvement. When classified by the type of movement disorder involved, CP is termed spastic, athetoid or ataxic. Other classifications of type include the terms spastic (which is often sub-classified by area of involvement, such as spastic quadriplegia), dyskinetic (including athetoid, choreoathetoid and dystonic), ataxic (affecting balance and depth perception) and mixed (in which a mix of types are seen in a single individual).

Early intervention is important for children with CP, as neuroplasticity allows the brain to reorganize itself in response to therapeutic activities.

It is important to be familiar with the latest information about cerebral palsy to best meet the needs of these clients. For example, persons with dyskinetic type CP typically have average intelligence and so should not be underestimated.

A QUICK ALS UPDATE: Between July 29, 2014, and the time of this writing, the ALS Association has received $115 million in donations from the Ice Bucket Challenge! These donations will chiefly be used to fund research toward finding a cure for this deadly disease.

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WWW.NINDS.NIH.GOV/DISORDERS/CEREBRAL_PALSY

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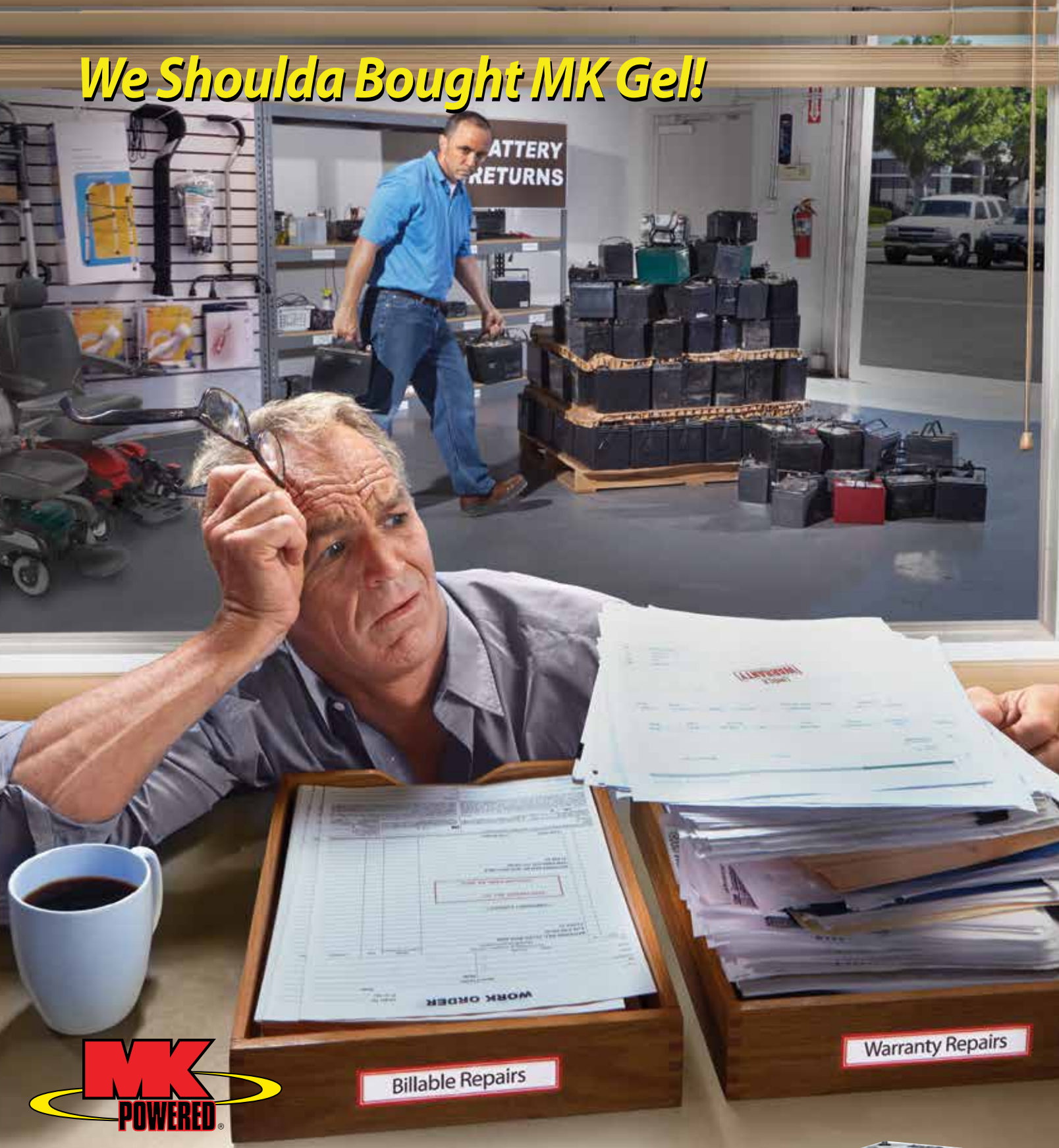

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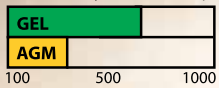

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CLINICAL CORNER

THE SIMPLICITY OF COMPLEX SEATING

WRITTEN BY: JILL SPARACIO, OTR/L, ATP/SMS, ABDA

In a rational world, one could assume that an individual with complex physical needs would require complex seating solutions. When broken down into basic components, the options facing the seating and mobility team have become simplified. With some basic principles to follow, seating the complex individual no longer has to be a challenge.

Complexity is in the eye of the beholder. To simplify the situation, seating professionals need to have a basic understanding of what constitutes complexity. Similar to a mobility system, complexity can be broken down into seating needs and mobility needs. One area should be tackled at a time, often starting with the seating, as this is the basis for function. The mobility options become more obvious once a position for function is determined. We will be focusing on seating solutions in this article.

A complex client can present many ways. I tend to think of a complex client as an individual who is unable to "fit" into ready-made seating options or as someone who has very specific issues with seating and mobility that require out of the box thinking. It is often assumed that clients need to sit in a traditional manner: upright head balanced over upright and level shoulders, level and upright pelvis with hips flexed to 90 degrees, and knees and ankles fully supported in an aligned manner. When we consider how we often sit throughout the day, all of us could be considered complex in our needs. Once we get away from the "traditional seated posture," we can be more successful in meeting clients' needs, including postural, functional and comfort.

Complex clients need to be viewed by presentation, not diagnoses. Although funding for seating is often diagnostically driven, the seating team needs to focus on presentation while considering the client's funding source. Complex clients can present with a variety of issues:

- Imbalanced or abnormal muscle tone
- Decreased strength and endurance
- Lack of active sitting skills due to absent or minimal function of the intrinsic musculature in the trunk
- Impaired sensation – hypersensitivity, as well as limited sensation
- Orthopedic/skeletal asymmetries – with or without the presence of neurological based muscle tone abnormalities

One of the common threads is a limited ability to participate in functional activities of daily living throughout the environments encountered on a daily basis.

EVALUATION PROCESS

As with all clients, the evaluation process is vital in determining seating needs. From the initiation of the evaluation, goals and outcomes will be determined. Through the interview process, needs and expected outcomes will be expressed by the client and caregivers. It is important that education also starts immediately. Clients with complex needs can have unrealistic expectations of the pursued equipment. For instance, a client with a severe scoliosis, pelvic obliquity and limited head control might identify that she would like to sit with her head in an upright position. It would be appropriate to address reasonable expectations of the recommended equipment.

ONCE WE GET AWAY FROM THE "TRADITIONAL SEATED POSTURE," WE CAN BE MORE SUCCESSFUL IN MEETING CLIENTS' NEEDS, INCLUDING POSTURAL, FUNCTIONAL AND COMFORT.

Although the mat evaluation is mandatory in all evaluation processes, it has even more importance when dealing with complexity. To fully understand motoric and postural limitations, a full picture of the client's abilities needs to be obtained. Since many complex clients present with motor limitations, sitting on the edge of a mat table may not be an option. Instead, the team members might need to use their bodies to provide the external support that the client needs to accomplish this task. As this support is increased or lessened, the evaluator determines how much external support is needed for an upright posture to be gained. This information helps lead to the recommendation of specific seating options. Individuals who are unable to sit independently or by using their hands on the mat table surface, often referred to as prop sitters, might need to spend some extended time in desired positions. The use of simulation can be helpful; either a planar simulator or a molding simulator can be used. Simulation helps the evaluation team and the client to determine if the desired position can be tolerated.

DETERMINING SEATING OPTIONS

As the evaluation process continues, discussion regarding possible seating options will occur. From the mat evaluation, the type, location and amount of external support will be identified. This can range from minimal support to total contact based on the client's needs. The mat evaluation findings are of utmost importance: Does the individual need contact at key points of control to maintain an upright posture or does he need total contact? What happens to his ability to participate in functional tasks when

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THE SIMPLICITY OF COMPLEX SEATING
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varying levels of support are provided? Is correction or accommodation needed? Many questions arise leading the team to address three different areas: angles of support, orientation of support and surface contours.

ANGLES OF SUPPORT

When seating clients with complex needs, a seating system can be either a success or a failure based on how the angles of support are set up. An individual who has only 75 degrees of hip flexion cannot be expected to sit in a seat- to-back angle of 90 degrees. Instead, the seating needs to be set at 105 degrees to accommodate this limitation. If not accommodated, transfers will be difficult, and the client's seated posture will not be maintained. If a posterior pelvic tilt is uncorrectable to neutral but flexible into greater asymmetry, a 90-degree, seat- to-back angle will not work. Instead, an accommodated position as determined during the mat evaluation is needed. Many seating systems for individuals fail due to simple errors with angles of support (see picture 1).

ORIENTATION OF SUPPORT

Orientation in space tends to be underutilized. Although many bases with tilt in space are used, clients and caregivers may be reluctant to actively change the tilt position once the initial set up is complete. Tilt needs to be varied throughout the day to offer optimal work positioning, pressure redistribution opportunities and periods of rest. Again, when looking at our own sitting patterns, we constantly change position, create pressure relief and seek comfort. Individuals with complex seating needs are frequently unable to do this. Instead, we have a history of locking clients into a position for function without regard to comfort. The use of tilt, whether power or manual, attendant or self-controlled, can offer this opportunity. Keep in mind that anterior tilt can be as beneficial as posterior tilt, especially to re-orient one's visual field and create a work ready position.

Another consideration for orientation in space is lateral tilt. This, provided on the base either through power or manual options, can help re-orient head and upper trunk positioning, provide pressure redistribution and facilitate basic vital function. Lateral tilt is very effective and underutilized for individuals with complex orthopedic issues. Lateral tilt can be beneficial to clients who have limited tolerance for posterior tilt or experience extreme postural instability. The movement into lateral tilt impacts the nervous system in a lesser manner, eliminating the discomfort that can go along with posterior tilt.

CONTOUR OF THE SURFACES

As important as angles of support and orientation in space is the contour beneath and behind the individual (see picture 2). As previously discussed, complex sitters are frequently prop sitters, relying on varying degrees of external support to maintain an upright position. Support surfaces can come in several presentations: planar, density contoured through foam, generically shaped foam or custom made foam options. The shape of the contour is dictated by the complexity of the client. For an individual who lacks active intrinsic muscle control of her trunk but has no orthopedic issues, a ready-made seat with different types of foam might be adequate. Softer foam under the ischial tuberosities with firmer foam under the femurs and more distal buttocks might provide more than enough stability, positioning assist and pressure redistribution. For an individual with a severe pelvic obliquity, and multicurve scoliosis with rotation, a custom seat would be needed to accommodate the asymmetry; otherwise very little contact would occur between a planar seating system and the client's body surfaces. The mat evaluation determines the location and type of support that is needed in the back. The support beneath the pelvis and thighs will also dictate the amount and type of support that is needed behind the individual's back. Keep in mind that as complexity increases, the amount of contour will probably also need to increase. Be aware of the natural and asymmetrical curves of the back. When seated, the body does not have a prominent lumbar curve and so a back support does not need a large lumbar support built in. Individuals who are lordotic will migrate away from lumbar supports; individuals who are kyphotic will tend to slide forward. Seating components need to simplify complexity, not increase it.

OUT OF THE BOX THINKING

Complexity does not always fit within the "box" that we think of when it comes to seating and positioning (see picture 3). For prop sitters who display significant skeletal asymmetries that cannot be corrected, accommodation has to occur. For that reason, we always needs to be open to "out of the box" solutions. Knees and lower legs do not need to be directly forward of hips and the pelvis. Attempts at

correction of severe asymmetries usually lead to poor outcomes. Compromise needs to be discussed throughout the evaluation process as goals are being generated. If an upright head position is the utmost goal but a severe multicurve scoliosis causes the head to be positioned laterally off the side of the "box," consideration needs to be given to nontraditional angles and orientation. By allowing the lower extremities to sweep to one side and accommodating the pelvic obliquity, improved head and upper trunk control can be gained. The team needs to problem solve how the lower extremities will be properly supported. Again, angles, orientation in space and contour of the support surfaces will provide the necessary solutions.

If an individual presents with severe limitations in hip flexion, a combination of orientation, angles and contours needs to be used. When opening the seat- to-back angle, the hip limitations can be accommodated, however this may impact the client's visual field. When an open seat- to-back angle is used in conjunction with anterior tilt, a more appropriate visual field can be gained. To prevent the person from sliding forward when anteriorly tilted, an exaggerated custom contoured seat may provide a solution.

PICTURE 1: The use of an open seat- to-back angle accommodates hip flexion limitations, leading to a more upright trunk and head position.

PICTURE 3: Nontraditional postures can allow for improved function for clients with complex needs.

In summary, seating for individuals with complex needs can be simplified by looking at three aspects: orientation in space, angles and contours. By considering these areas throughout the evaluation process, function can be enhanced and problems minimized. The use of a skilled seating team facilitates the process when each member brings his or her expertise to the evaluation.

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PICTURE 2:The key to successful wheelchair positioning is the location and amount of support provided.

REHAB CASE STUDY

PEDIATRIC POSITIONING:

HEY WHEELCHAIR MAN, HOW SMALL CAN YOU GO?

WRITTEN BY: CRAIG KRAFT, BS, ATP/SMS AND RICHARD BESETT, ATP

Working in a busy pediatric orthopedic clinic provides daily opportunities for recommending and providing seating and mobility equipment. As the ATP/SMS certified seating specialist[1] at Tampa Shriners Hospital for Children, challenging requests are routinely encountered to meet the orthopedist's goals to correct, prevent or support orthopedic distortions and skin problems, while at the same time ensuring the child's functional ability to propel a manual chair or drive a power chair is not compromised. To ensure favorable outcomes, multiple pieces of information from everyone involved with the child must be considered. What is the optimal outcome? This results when everyone's needs identified in the initial equipment assessment are satisfied. Who is everyone? Not only are the physician and clinician recommendations essential, equally important are the child's needs, the family structure and activities, community activities, transportation requirements, as well as access to the school and home environments. Sometimes, augmentative communication or computer access must also be considered and integrated with the seating and mobility equipment.

Recently, a special child who exemplifies the complexity and multiple needs of the population served in our clinic required a new seating system to meet his functional, positional and orthopedic goals. A 15-month-old male client has a diagnosis of Rhizomelic Chondrodysplasia Punctata Type 1, often called RCPD[2]. RCPD 1 affects fewer than 1 in 100,000 people worldwide and is more common than RCPD 2 and RCPD 3. RCPD results from mutations in one of three genes. Mutations in the PEX7 gene, which is most common, results in RCPD 1. Changes in the GNPAT gene lead to RCPD 2 and, AGPS gene mutations result in RCPD 3. The genes associated with RCPD are involved in the formation and function of structures called peroxisomes. Peroxisomes are sac-like compartments within cells that contain enzymes needed to break down many different substances, including fatty acids and certain toxic compounds. Peroxisomes are also important for the production of fats (lipids) used in digestion and in the nervous system. RCPD is a condition that impairs the normal development of many parts of the body. The major features of this disorder include skeletal abnormalities, distinctive facial features, intellectual disability and respiratory problems. Most children with this condition do not achieve developmental milestones such as sitting without support, feeding themselves or speaking in phrases.

WHAT IS THE OPTIMAL OUTCOME? THIS RESULTS WHEN EVERYONE'S NEEDS IDENTIFIED IN THE INITIAL EQUIPMENT ASSESSMENT ARE SATISFIED.

PICTURE 1

Convaid Cuddle Bug 2

Affected infants grow much more slowly than other children their age, and many also have seizures.

The child was referred to our clinic by his therapist with concerns about his hip position resulting in decreased range of motion. The family was also concerned about his hands and feet. The child is followed by genetics, receives therapies on a regular basis, and has lately been hospitalized for respiratory issues. He has a gastrostomy tube and has a history of multiple eye surgeries to treat bilateral cataracts.

The medical staff conducted a physical exam of the child and noted shortened humeri and femora, rib cage asymmetry, and bilateral upper and lower extremity joint contractures, particularly at the shoulders, elbows and hips. However, his feet were in a neutral position and were flexible. The child's skin is intact. Due to his preferred hand and wrist position,

upper extremity splints were recommended secondary to right wrist flexion with internal rotation. More significant were the results of the child's X-rays. He had a 30-degree right thoracolumbar positional curve that could be reduced approximately 50 percent with corrective hand forces simulating thoracic lateral supports. The radiograph of the pelvis showed a lack of formation of the femoral heads. The femora were quite widened and shortened with calcifications noted, consistent with his diagnosis. As a result of his clinic visit, the child was referred to occupational therapy for hand splints and for a seating evaluation for improved positioning in his Convaid Cuddle Bug 2 Wheelchair[3].

Upon initial assessment, a Convaid Cuddle Bug 2 Adaptive Stroller, classified as a compact folding tilt in space wheelchair (HCPCS code of #E1232), would appear to be a good choice for the child with supportive seating (see picture 1). However, the one provided for the child was simply too large to fit his body correctly for upright midline sitting alignment as the seating supports could not be adjusted for his small size (see Table 1).

As a result, the family was forced to keep the seat- to-back angle open and the seating system tilted back to keep the child comfortable and maintain his posture. He was literally looking at the ceiling. A challenge was presented to us to meet the child's positioning and functional needs as this system could not be modified and only a few commercially available products were on the market, which could accommodate his size. One option discussed was a custom sized Jay Sure Fit Lil Kiddos® seating system[4] mounted on a pediatric tilt wheelchair base.

However, this did not meet the family's preference for the stroller base style. We next considered the Otto Bock NUTEC seating system[5], although when comparing the pricing to our cost to fabricate, we opted to build our own system. The available funding had been exhausted and, with the authorization of the Cuddle Bug 2, those replacement costs would need to be taken care of by Shriners Hospitals for Children. Instead, we decided to offer an in-house custom-made seating system on a commercially available Otto Bock Kimba Spring stroller base that we had in stock.

The custom-made seating insert consisted of a padded I-cut backrest and cushion using an AliMed® T-Foam™ [6] one inch soft foam package. Custom-made lateral trunk supports with Lil Kiddos® mount hardware, as well as a custom made anterior trunk support

(CONTINUED ON PAGE 44)

PICTURE 2

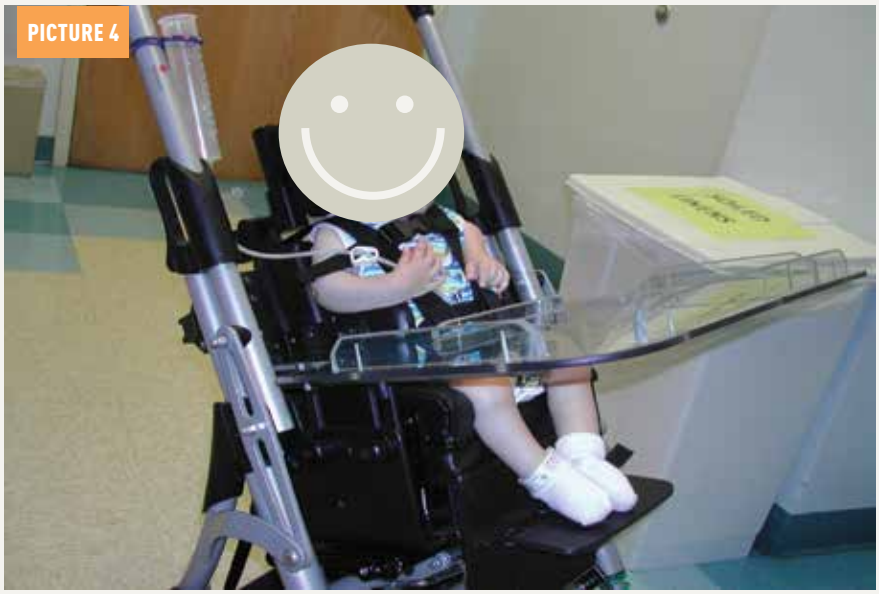
The custom seating system interfaced to the Otto Bock Kimba base.

PEDIATRIC POSITIONING
(CONTINUED FROM PAGE 43)

"WITH TEARS IN MY EYES I WANT TO SAY THANK YOU!!!! OUR LITTLE GRANDSON IS 18 MONTHS OLD NOW. THIS IS THE FIRST TIME HE HAS BEEN ABLE TO SIT UP ON HIS OWN (WELL, WITH THE HELP OF HIS NEW CHAIR) AND SEE THE WORLD. YOUR SEAT SPECIALIST AND DOCTORS AT THE TAMPA FACILITY ARE THE MOST AWESOME PEOPLE ... "

(chest harness) were fabricated. The upholstery covers for the backrest and planear seat cushion consisted of Dartex®[7] on the weight bearing surface. Dartex is a waterproof four-way stretchable breathable fabric that was sewn into Naugahyde side panels and backing to cover the seat and backrest cushions. We installed a Stealth NinÕ head support with a single one-piece sub-occipital pad (QCR #SU118). The head support was attached to the multi-axis removable headrest mount[8] system. We fabricated an adjustable height and depth solid back and seat base with a one-piece footplate (made from Starboard® plastic from the King Plastic Corporation in ¼" thickness[9]. Adjustable width and height lateral trunk supports and adjustable width lateral pelvic supports were incorporated. A custom cutout Lexan® tray[10] was also fabricated (see picture 2).

We estimate eight hours of labor was involved. In addition to the cost of commercial components and fabricated materials, we estimate our cost for the seating insert and tray is $940. This cost is approximately half of the cost of comparable commercial options



The child three-quarter view.

that were available. The Otto Bock Kimba Spring base was donated from the community for this very purpose.

The custom seating insert was modified on the bottom to accept the Otto Bock quick release system that interfaces to the Otto Bock Kimba Spring base[11]. The Otto Bock commercial canopy was used for those sunny or rainy Florida summer days. Our custom seating system is able to operate exactly the same as the Otto Bock commercial seating system offerings. Pulling the lever on the quick release interface allows us to remove the custom seating system and allow folding of the base. We instructed the family to continue to use the child's car seat for transportation, as our fabricated seating insert is not crash tested.

Upon initial fit for his new tilt in space seating system, the child was able to sit upright with spinal alignment and maintained midline head, trunk, and pelvic positioning to meet the need for orthopedic support (see pictures 3 and 4). Secondly, because his trunk was in a more extended position his diaphragm had the potential to function more optimally to facilitate deeper breathing and increased air-to-lung volume. This position also benefits digestion[12]. The child now had the opportunity to work on head and trunk control in an upright position and use his hands for grasping and other developmentally appropriate activities with the tray.

The custom chest harness required modification to lower the cross strap and buckle away from his throat. Custom extended plastic tray mounts and elbow pads were made to raise his tray height closer to his elbow height to promote developmental activities. No wheelchair man is perfect.

Feedback ensures growth and learning, which will contribute to improved strategies, techniques and appropriate recommendations of products to meet the needs of our patients. The child's grandfather wrote to us:

"With tears in my eyes I want to say thank you!!!! Our little grandson is 18 months old now. This is the first time he has been able to sit up on his own (well, with the help of his new chair) and see the world. Your seat specialist and doctors at the Tampa facility are the most awesome people. Y'all have given him something we

would never have been able to afford. His new chair is just, just … well I don't have words to say. Again, thank you and all the staff there."

By using all the information available from each stakeholder and prioritizing everyone's needs, in this case the desired outcome was successfully reached and our costs were ultimately reduced.

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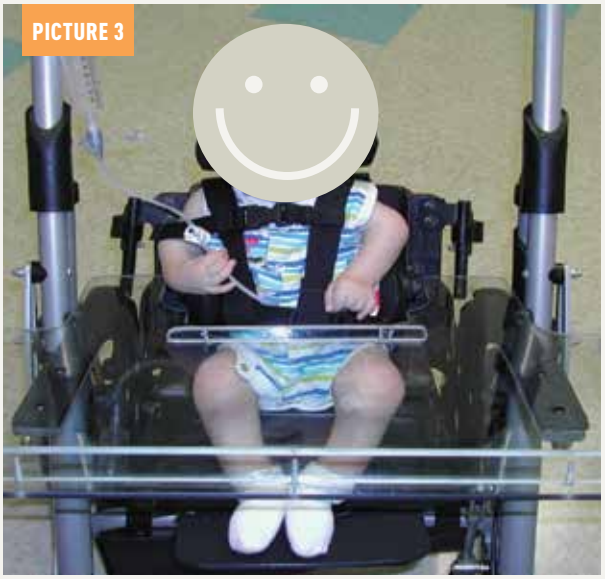
PICTURE 3



The child on initial fit.

TABLE 1

Measurements		
Dimensions/ Adjustment Range	**Cuddle Bug 2 Wheelchair**	**Rayland's Body Measurements**
Seat depth	**7-10 inches**	**4 ½ inch**
Seat width	**9-12 inches**	**5 ½ inches**
Back Height	**17 inches**	**8 ½ inches**
Thoracic pad		**3 inches high by 3 inches long**
Popliteal to Heel Drop	**5-13.5 inches**	**4 ½ inch**
Headrest Adjustment	**14-25 inches high**	**Top of head 14 inches**

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USERS FIRST

STRONGER ADVOCACY AND IMPROVED WHEELCHAIR EVALUATIONS

WRITTEN BY: JENN WOLFF AND ALEX BENNEWITH

When starting a new year, I find it is a great time to rehash the good and the not-so-good of the past year. Last year was a great year for me personally. I began managing UsersFirst, attended CELA and the third annual Roll on Capitol Hill; helped the Clinician Task Force educate the American Occupational Therapy Association's Representative Assembly (their "Congress") about an inadequate position paper for Seating and Wheeled Mobility showing the need for extensive guidance for therapists on the education and skills needed to complete Complex Rehab Technology (CRT) evaluations; and Alex and I started United Spinal Association's Grassroots Action Network across the country for consumers, clinicians and passionate advocates to expand and strengthen grassroots action and our national network of advocates and wheelchair users.

United Spinal has gone through some major changes and is now a more unified and more powerful association. Take a look at our new UsersFirst content at the UsersFirst Grassroots Action Network http://www.unitedspinal.org/usersfirst-grassroots-action-network/.

Check back in early 2015 for additional education and information for the United Spinal network and a new and improved Mobility Map. The map was created out of a need to educate wheelchair users on what should happen during a CRT evaluation and who their "team" is. It goes step-by-step through the process, from getting an order to receiving the chair. I think it is very important for the wheelchair user to understand who the "team" is, what each member does and the expectations of each member. But even more importantly, the wheelchair users should know about the options he or she has and how to be best prepared for the evaluation. The wheelchair checklist/self-assessment is a great start, but more information is needed to help the team justify the equipment.

As UsersFirst, we make changes from the ground up. By making the process more transparent, the wheelchair user can actually be part of the "team," make informed choices and have higher expectations from the team. If we, the end user, demand better service, more experienced clinicians, and more choice, we may help change the system from the ground up.

To do this, a group of us at United Spinal will be translating the information in the Mobility Map to manageable sections that can be shared with consumers, clinicians and suppliers alike. For example:

- "Before Your Evaluation" – put all your information together (medical history, daily activities, home measurements)
- "The Wheelchair Team" – members, definitions and how to find them
- "What to Expect at an Evaluation" – measurements, getting out of the chair for accurate seating and positioning, importance of having clinician and ATP working together (especially for CRT)
- "When You Get Your New Chair" – try to have it delivered to your home and perform transfers, etc., to make sure the chair fits and works in your environment, be educated about the chair

Some clinicians have also stated that they may be willing to video a "model" wheelchair evaluation to use with this new format.

WE HOPE THAT BY PROVIDING A NEW AND IMPROVED MOBILITY MAP THAT SUPPLIERS CAN GAIN MORE LOYAL CUSTOMERS, CLINICIANS WILL HAVE AN EASIER TIME WITH DOCUMENTATION, AND WE WILL BE MORE SATISFIED WITH THE EQUIPMENT.

The process to reconfigure the Mobility Map has just begun. Please let us know if you have any suggestions for us on how to make it more useful for suppliers and clinicians. We hope by providing a new and improved Mobility Map that suppliers can gain more loyal customers, clinicians will have an easier time with documentation and we will be more satisfied with the equipment.

Even though CRT legislation is gaining ground, let's help the whole process become more efficient and less cost-prohibitive with sensible regulation. Let's make this a 2015 we all can be proud of.

CONTACT THE AUTHORS

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MEDICARE MODIFIERS:

CHANGES & CORRECTIONS … EFFECTING YOUR PAYMENTS

WRITTEN BY: CLAUDIA AMORTEGUI

KY modifiers and incorrect payments – it seems like this has been the never-ending story. Hopefully, we can now close the chapter on this book, however it is up to you to make it count. Recently, I have written several articles for DIRECTIONS regarding Medicare's consistently wrong payments of many options on non-competitive bid complex rehab wheelchair bases. When I said consistently, I meant a year and a half. Medicare was paying those options at the Competitive Bid Single Payment Amount versus the actual fee schedule, which is the amount it should pay when the options are on all complex rehab wheelchair bases (non-competitive bid bases).

Since these articles, Centers for Medicare and Medicaid (CMS) published CR8864 and it went into effect Jan. 1. Although Medicare feels the problem has been addressed, this is only for the new claims – 2015 and forward. It is now up to you and your billing team to collect the difference in the wrong payments (and in some cases a full payment) for those claims processed between July 1, 2013 and Dec. 31, 2014.

TO SOME, THIS ARTICLE MAY READ LIKE A FOREIGN LANGUAGE WHEN IT COMES TO MODIFIER USAGE. BE SURE TO GET THIS INTO THE RIGHT HANDS – REIMBURSEMENT/ BILLING STAFF AND MANAGEMENT.

The requirements to obtain these payment adjustments differ just a bit amongst the four Medicare jurisdictions. However, the corrections are being done through their reopening's process. Thankfully, you do not have to submit each individual claim. Most jurisdictions are just asking for a submission of each PTAN that received improper payments and a separate submission for each PTAN that was wrongfully denied due to not being a "contracted provider" when it was not required. Again, this is just for some options on your CRT claims, but I promise, it adds up. Collect what is rightfully yours. Be sure to check with your individual Medicare contractor to get the exact details of what you need to do.

As for some new modifier rules…

Effective Jan. 1, Medicare made a change to some required modifiers on certain manual wheelchair orders. Prior, the KY modifier was only to be used on certain power wheelchair claims. Medicare has now added the required use of the KY modifier on certain options for those manual wheelchair bases that are not competitively bid. You will still use the KE modifier where appropriate but now you will also use the KY. Per CR8864, the KE **and** KY modifier should be used on wheelchair options/ accessories that are competitively bid in **both** Round 1 **and** Round 2 when billed on a non-competitive bid manual wheelchair base (K0005, K0009, K0898, E1161, E1229, E1231 – E1239).

An example is if you were providing laterals (E0956) with swing-away hardware (E1028) on a tilt-in-space manual wheelchair (E1161). The base is not part of the competitive bid program but these two accessory codes are. Since these items are being placed on a non-competitive bid base, they are not subject to the competitive bid pricing. To ensure you are paid at the standard fee schedule rate you would bill these option codes with the following modifiers:

- Appropriate pricing modifier (NU-new purchase; UE – used purchase; RR – rental)
- Left and/or right modifiers (LT, RT)
- KE modifier – code E0956 and E1028 can be used on a manual or power wheelchair – the KE will ensure you are paid at the higher rate since they are on a manual wheelchair base for this example – remember, several years back the industry agreed to a 9.5 percent cut in payment for options on a power wheelchair base.

The Clinicians Task Force is a group of clinician...

- Expert practitioners
- Contributors to evidence based outcomes
- Advocates for end users and caregivers

Who

- Provide education, consultation and treatment
- Influence standards of practice with professional organizations
- Mobilize grassroots action for policy and legislative changes
- Promote "best practice"
- Contribute to the healthcare continuum

- KY modifier – now required for certain option codes that are being placed on a non-competitive bid base (manual or power).

- KX modifier – this can only be used if you have all the required documentation and if the client qualifies under Medicare coverage criteria.

Most providers have their systems programmed to automatically add some, it not all, modifiers; if their system is not programmed the staff is. You need to be certain that these changes are made within your system and that the staff is educated on the changes. If this is not done, you will see unnecessary denials and/or decreased payments.

To some, this article may read like a foreign language when it comes to modifier usage. Be sure to get this into the right hands – reimbursement/billing staff and management. If you are not on top of the changes and the ability to request corrected payments, the only one who loses is you – the provider. Your margins have already been decreased enough; there is no need to give away more money.

I hope to see you in Nashville at the International Seating Symposium.

CONTACT THE AUTHOR

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CLINICIAN TASK FORCE

CLINICIAN TASK FORCE 2014 ACCOMPLISHMENTS & 2015 PRIORITIES

WRITTEN BY: LAURA COHEN PHD, PT, ATP/SMS

The Clinician Task Force (CTF), established in 2004, is a small but mighty group comprised of 45 volunteer members. The majority of our members are practicing seating and wheeled mobility (SWM) clinicians representing reputable regional medical centers and rehabilitation facilities. Our group fills an important and distinctive role. We are the only group focused on representing the clinical voice for CRT issues. Our small 501(c4) nonprofit organization and structure allows us the ability to be responsive to CRT issues in a timely and efficient manner.

In the past year, the CRT industry as a whole has had a busy agenda working to ensure individuals with mobility impairments have appropriate access to CRT products and services. The beginning of a new year is a perfect time to pause, look back at our progress and accomplishments, and set priorities for the coming year. It is well-recognized that the CRT industry has faced our fair share of challenges in 2014 and expected that 2015 will be more of the same.

WHAT WE HAVE LEARNED:

"... [W]HATEVER LIFE THROWS AT US, OUR INDIVIDUAL RESPONSES WILL BE ALL THE STRONGER FOR WORKING TOGETHER AND SHARING THE LOAD." QUEEN ELIZABETH II

CRT stakeholders including consumers, clinicians, advocates, suppliers, CRT companies and manufacturers continue to team together to carry our message to policymakers and legislators to influence and effect change. Our numbers are small and workload vast. Involvement, whether it be via sweat equity or financial support, is particularly important in 2015 to see our CRT legislation successfully passed into law. Piecemeal solutions and Band-Aid workarounds are simply unsustainable. All hands on deck are needed to ensure consumers retain access to high quality CRT services and devices!

HIGHLIGHTS OF 2014 CTF ACCOMPLISHMENTS:

The CTF is leading the way in engaging the clinical community. Through ongoing, consistent communication, education, meetings and letters our teamwork has had some successes worth celebrating. Let's take a moment now to acknowledge and recognize our accomplishments.

• Secured sponsorship for CRT legislation: CTF members have been instrumental in influencing co-sponsorship support and participating in meetings with Congressional leads, target representatives, and Centers for Medicare and Medicaid (CMS) officials to represent clinical perspective.

• Communicated and met with CMS officials and contractors: Concerning recategorization to Capped Rental, PMD Prior Authorization Expansion, NCB Fee Schedule Expansion and Demonstration of Bundled Payments, PMD E Clinical Template, and therapy cap impact on provision of CRT specialty evaluation.

• Provided clinical support to state CRT legislative activities: Updated and informed state chapters of APTA/AOTA on CRT Legislative activities, provided input to legislative language, and advocated for support and information dissemination. Submitted comments to CA MediCal related to access issues with 10 percent fee reduction.

• Edited CRT Special Issue in "Journal Topics in Geriatric Rehabilitation" Planned, developed and contributed to special issue to publish research, practice and policy content specific to SWM and CRT practice available on line and due for publication in February 2015.

• Led APTA on CRT Issues:

o Represented CRT issues with APTA leadership and staff, assisted in developing official comments to CMS rulemaking on expansion of NCB pricing and demonstration of bundled payments, and expansion of PMD prior authorization program.

o Authored new AT/CRT section included in APTA Guide to PT Practice (3.0) and SWM clinical documentation guide and resources designed to prepare the clinical community with defensible documentation practices.

o Established a SIG for AT/SWM within the Neuro Section creating a home within the organization for education, training, advocacy, research and outreach activities.

o Surveyed 529 PT/PTA accredited academic programs about entry-level SWM education to identify pre-service training needs and opportunities.

• Led AOTA on CRT issues: Implemented a strategy to define SWM professional competencies, ratify the definition of CRT practice, and promote CRT legislative and regulatory activities within the organization.

• Participated as committed member to E Clinical Template Initiative with HHS and CMS: Served as subject matter expert and participant providing input and comment to initiative to develop, test and implement electronic health record solutions for PMD electronic collection, transmission and review of PMD claims.

CTF TOP STRATEGIC PRIORITIES FOR CY2015:

We believe the various initiatives we are focused on are critical to protecting and promoting access to CRT. The year 2015 promises to have no shortage of increasing CRT access issues on the federal and state level.

The financial support of our donors is critical to enable the CTF to continue its important work in support of activities aimed at protecting and improving access to CRT for people with disabilities. Thank you to the CTF donors who continue to support our work!

CONTACT THE AUTHOR

Laura may be contacted at laura@rehabtechconsultants.com or 404.370.6172.

OBJECTIVES	ACTIVITIES
PASSAGE OF CRT LEGISLATION	1. PARTICIPATE IN CRT STEERING COMMITTEE AND WORK GROUPS TO FACILITATE PASSAGE AND IMPLEMENTATION OF CRT LEGISLATION 2. MOBILIZE THE CLINICAL COMMUNITY TO LOBBY FOR PASSAGE OF CRT LEGISLATION
PROVIDE CLINICAL GUIDANCE TO POLICY MAKERS TO ENSURE CONSUMERS HAVE CONTINUED ACCESS TO CRT PRODUCTS AND SERVICES	1. RESPOND TO LEGISLATIVE AND REGULATORY ISSUES AT THE STATE AND FEDERAL LEVEL THAT IMPACT CONSUMER ACCESS TO CRT ITEMS AND SERVICES
BUILD CAPACITY OF CLINICIAN WORKFORCE TO PROVIDE SKILLED CRT CLINICAL SERVICES	1. PLAY CRITICAL AND ACTIVE ROLE IN PROMOTING CRT WITHIN THE APTA AND AOTA: a. Promote CRT issues in practice, payment, policy and advocacy activities within respective organizations b. Mobilize clinicians from diverse settings and locations to engage in CRT advocacy and training activities c. Represent CRT related issues at Neurology Section Strategic Planning Meeting on Education responsible for defining academic program requirements for entry-level preparation. 2. CREATE SEATING AND WHEELED MOBILITY TRAINING MATERIALS FOR PRE AND POST SERVICE TRAINING: a. Explore options for developing SWM Certificate program to assist practicing clinicians in developing SWM expertise. b. Develop dissemination method to reach broadest group of clinicians from diverse settings (e.g. acute care, inpatient rehab, SNF, assistive living, school, veteran's facilities, etc.) c. Prepare the workforce to ensure there is ample access to qualified and skilled clinicians to provide specialty evaluations and are knowledgeable about documentation and payment policies 3. PROVIDE SUPPORT TO DEDICATED SEATING WHEELED MOBILITY CLINICS TO JUSTIFY EXISTENCE.
PARTICIPATE IN HHS ELECTRONIC STANDARDS FOR MEDICAL DOCUMENTATION INITIATIVE (ESMD)	1. CONTINUE TO TRACK AND PARTICIPATE IN ESMD STANDARDS AND INTEROPERABILITY FRAMEWORK MEETINGS PROVIDING CLINICAL INPUT TO DEVELOPMENT OF PMD ELECTRONIC DOCUMENTATION TEMPLATES.

RESNA

MARKETING YOUR CERTIFICATION CREDENTIAL

WRITTEN BY: ANDREA VAN HOOK

Congratulations, you've achieved your certification! All of that hard work has paid off. Now what?

It's time to start marketing yourself as a certified professional. If that thought fills you with dread, you are not alone. Most people hate marketing themselves. But if done right, marketing leads to more referrals and opportunities, which is probably why you wanted your certification in the first place.

On the RESNA website, there is a helpful page called "Marketing Your Credential," with some tips and templates you can download to help with your marketing efforts. You will find:

- A press release template
- Certification logos (ATP and ATP/SMS)
- Logo guidelines
- A candidate brochure that you can use with other professionals and your employer
- A consumer-oriented brochure that you can use with clients
- Microsoft® PowerPoint® slides describing certification you can use in presentations

IT'S TIME TO START MARKETING YOURSELF AS A CERTIFIED PROFESSIONAL. IF THAT THOUGHT FILLS YOU WITH DREAD, YOU ARE NOT ALONE.

HOW TO GET STARTED

First, let everyone know that you've achieved your certification. Here are some suggestions:

- Tell your boss. If your employer has a marketing or communications staff person, ask if it's appropriate to let that person know as well. (If you own your own business, take yourself out to lunch to celebrate and skip to bullet #3.)
- Ask your boss if he or she can send out an email announcement to the entire staff. Don't assume that they will know how to describe your credential. Use the press release template to put together the email for them so it's easy.
- Immediately start using your credential (ATP, ATP/SMS, RET) in your email signature line and have it added to your business cards, along with the logo.
- Familiarize yourself with the certification logo guidelines. You poured blood, sweat and possibly some tears into getting this certification, so use the logo everywhere you can.
- Check the "Find the ATP" tool on the RESNA website. Make sure your information appears in search results and that it's correct. Search by state, city, certification, and anything else you can think of, and check the results. Contact the RESNA office if there are any issues.
- Customize the press release template with your information and send it to your local newspaper and the local business journal, if there is one. Most publish news about recent hires, promotions, etc., and have submission guidelines and forms for this type of news. Look for that and follow the instructions. If it's an online publication, send the link to your boss and others you know once your information is posted.
- Yes, you need a headshot. It's great if you can get it professionally done, but any smartphone takes a good

MARKETING DOESN'T STOP AFTER YOU'VE LET EVERYONE KNOW! MAKE MARKETING AN ONGOING PART OF WHAT YOU DO PROFESSIONALLY.

picture. Have a friend or a colleague take the photo – no selfies, please! Dress professionally and stand in front of a clean background, just like school picture day. Smile. Use a simple editing program like Paint to crop or resize the picture if necessary. The picture needs to look like you (the way you are today, not 20 years ago) so people can recognize you. For some folks, taking a picture of themselves is an anxiety-ridden endeavor – sorry about that. The good news is you can use the headshot for about two or three years before you should do it again!

- Let any groups you belong to know your good news, including your church community, volunteer organizations, the PTA, etc. Post the news on your personal Facebook page (along with your new headshot). You never know where a referral can come from.

NOW, KEEP IT UP

Marketing doesn't stop after you've let everyone know! Make marketing an ongoing part of what you do professionally. Some ideas:

- Download the consumer education brochure available on the RESNA website and use it. Print out color copies at home if you have a color printer, or take the digital file to a Fedex Kinko's. You can also order printed copies for a nominal fee from RESNA (there's an order form on the website). Hand the brochure

(CONTINUED ON PAGE 54)

MARKETING YOUR CERTIFICATION...
(CONTINUED FROM PAGE 53)

out to clients and their families and/or caregivers. Explain what your certification is and how it helps them. For example, you can explain that they will always get advice on the best technology for their particular needs, regardless of the products that you may be representing.

• Reach out to local senior citizen groups or disability organizations in your area and offer to do a presentation on assistive technology. Use the Microsoft® PowerPoint® slides available on the RESNA website in your presentation. Remember to bring plenty of business cards and the consumer education brochure.

AS MY MOTHER ALWAYS SAID, "LET PEOPLE KNOW YOU'RE FABULOUS – IT'S NOT BRAGGING WHEN IT'S TRUE."

• Using the "Find the ATP tool" on the RESNA website, look up other assistive technology professionals who are in your geographic area, but focus on a different specialty than you. Email them to introduce yourself, describe what you do, and ask for their information so you can do referrals. Chances are they will start referring to you as well.

• Join LinkedIn. Seriously, it's time. Set up a public profile (using that great headshot) and join some groups that are focused on assistive technology (there's a RESNA group, by the way). You can make connections and learn more about different types of technology, plus share your own knowledge.

• Let people know when you've taken a continuing education class or have read something interesting. Keep an email list of people who could send you referrals, and send them occasional updates and links to articles that are relevant. Don't overdo it – you don't want to be a pest; once a quarter is plenty. (Side tip: make sure you know how to use the bcc function on your email client

so you don't give away all of your contacts to others, or worse, have someone hit "reply all" and blast everyone you know with their own details.)

Yes, marketing can be a pain – and you're hearing this from someone who does it for a living. The good news is that with certification, you have achieved something worth telling people about – you have independent verification that you are a serious, committed, and knowledgeable assistive technology professional. As my mother always said, "Let people know you're fabulous – it's not bragging when it's true."

CONTACT THE AUTHOR

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WE LOOK FORWARD TO A WONDERFUL YEAR!

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NRRTS REGISTRANTS

Congratulations to the newest NRRTS Registrants. NOV. 20, 2014 THROUGH JAN. 27, 2015.

Jasmine Libarian, ATP, RRTS®
Forever Active Inc.
1 W Mountain St Unit 9
Pasadena, CA 91103
Telephone: 626-389-8790
Fax: 626-466-3020
Registration Date: 1/2/2015

Daniel J. Perkins, ATP, RRTS®
Alternative Care Providers, Inc
275 Billerica Rd
Chelmsford, MA 01824
Telephone: 978-251-7077
Fax: 978-418-0233
Registration Date: 12/18/2014

CRTS®

Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential.

NAMES LISTED ARE FROM NOV. 20, 2014 THROUGH JAN. 27, 2015.

David Gurganus, ATP, CRTS®
A&A Home Health Equipment
Hattiesburg, MS

Ruben Jones, MS, ATP, CRTS®
Active Mobility Innovations
Largo, FL

David A. McNair, ATP, CRTS®
AmeriMed Pharmacy & Equipment
Valdosta, GA

David Scott Pickett, ATP, CRTS®
Numotion
Tallahassee, FL

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS, and who has not.

NAMES INCLUDED ARE FROM NOV. 20, 2014 THROUGH JAN. 27, 2015.

For an up-to-date verification on Registrants, visit **www.nrrts.org**, updated daily.

David Petrea, ATP, Gray, TN

William Weber, ATP, Tampa, FL

As Corporate Friends of NRRTS, these companies recognize the value of working with NRRTS Registrants and support NRRTS' Mission Statement, Code of Ethics and Standards of Practice.

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NATIONAL CRT LEADERSHIP & ADVOCACY CONFERENCE

Including CELA

Hyatt Regency Crystal City - Arlington, Virginia
April 21-23, 2015
Presented by NCART and NRRTS

Join CRT providers, manufacturers, consumers, and others to protect and promote access to CRT!

The National Coalition for Assistive and Rehab Technology (NCART) and the National Registry of Rehabilitation Technology Suppliers (NRRTS) are partnering to hold the 3nd annual National CRT Leadership and Advocacy Conference. The conference brings CRT stakeholders together in one place for high value education, networking, and advocacy.

Program details are being finalized and registration is open. Register online at www.ncart.us or www.nrrts.org. For additional information contact Don Clayback at NCART at dclayback@ncart.us or Weesie Walker at NRRTS at wwalker@nrrts.org. We look forward to seeing you there!

Conference sponsorships are available at the Platinum ($10,000), Gold ($5,000), Silver ($2,500), and Supporter ($1,250) levels. The Conference Sponsor Form outlines the benefits and can be found at www.ncart.us/crtconference.

TWO REGISTRATION OPTIONS

OPTION 1– FULL CONFERENCE
Leadership/Advocacy/Capitol Hill Visits

NRRTS Registrants or Friends of NRRTS- $395
NCART Members-$395
Other Attendees- $495

Discounts available for companies sending multiple attendees

OPTION 2– ADVOCACY ONLY
Advocacy/Capitol Hill Visits

NRRTS Registrants or Friends of NRRTS- $225
NCART Members-$225
Other Attendees-$295

CONFERENCE SCHEDULE

Leadership Day
Tuesday, April 21, 2015

7:30am to 8:30am – Registration
8:30am to 5:00pm – General & Breakout Sessions
6:00pm to 8:00pm – CRT United Reception

CRT focused presentations for providers and manufacturers to help them better manage and grow their businesses in these challenging times.

Advocacy Day
Wednesday, April 22, 2015

7:30am to 8:30am – Registration
8:30am to 5:00pm – General & Breakout Sessions
5:00pm to 6:00pm – Congressional Prep Meeting

Funding and advocacy sessions for CRT stakeholders to help them better protect access to CRT on Federal and State levels.

Capitol Hill Visits Day
Thursday, April 23, 2015

9:00am to 4:00pm – Capitol Hill Visits
5:00pm to 7:00pm – Debriefing Reception

Consumers, clinicians, providers, and manufacturers will take the CRT advocacy message directly to Congress through in-person meetings on Capitol Hill.

For additional information please contact **Don Clayback** (dclayback@ncart.us) or **Weesie Walker** (wwalker@nrrts.org).

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